DR. SONKEN

appendix

REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE

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REPORT
OF
THE
SECRETARY'S
COMMISSION
ON
MEDICAL
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JANUARY 16, 1973

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PREFATORY NOTE

In his February, 1971 Health Message, President Nixon directed the Secretary of Health, Education, and Welfare to convene a commission on Medical Malpractice "to undertake an intensive program of research and analysis in this area." Pursuant to this mandate, the Secretary's Commission was convened, a research plan was developed, and a contract research program was initiated, focusing on as many significant factors of the malpractice problem as time would allow. This volume contains the results of that research program, as well as various analytic studies prepared by staff members for the consideration of the Commission.

Although these reports, studies, and analyses vary in scope and quality, collectively they represent the first large-scale effort to research a problem area that has not been subjected to in-depth analysis heretofore. By their very nature, some of these reports, studies, and analyses are of limited value or contain findings, conclusions, and recommendations which the Commission does not endorse. Others have provided valuable resource data for specific Commission findings and recommendations, and in many instances they are so referenced in the Commission's official Report to the Secretary.

For the stated reasons, the inclusions of these reports, studies, and analyses in this Appendix does not constitute blanket endorsement by the Commission or by the Commission staff of their completeness or accuracy. They are published primarily to serve as resource material for future students of the malpractice phenomenon, and no other interpretation should be given to their inclusion herein.

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INTRODUCTION

Although prior to establishment of the Commission much had been written about the medical malpractice problem and its assumed causes and consequences, very little of what had been written was based on documented fact. The major conclusion of those who had tried to analyze various aspects of the medical malpractice problem was that it could be better understood only if a large body of data were to be made available. The Secretary of Health, Education, and Welfare, in his charge to the Commission, directed that a program of research be conducted to gather such a body of data:

> "The Commission will carry out its responsibilities by reviewing and evaluating information and statistics relating to the malpractice phenomenon tendered by professional and industry groups, members of Congress, medico-legal experts, Federal agencies, and the general public. In addition, the Commission will review and evaluate statistical data and other information relating to the malpractice phenomenon obtained by means of a series of studies conducted by the Department, primarily through contracts with non-governmental research organizations, universities, and the like."

This Appendix to the Commission's Report contains a series of documents produced in the pursuit of this charge. They originate from two basic sources: (a) reports generated by knowledgeable individuals and research firms pursuant to contracts with the Commission, and (b) papers generated by the Commission staff. Some of the studies and reports were based on existing information while others were based on original research or data-gathering efforts.

Extending over an extremely short period of time, considering the complexity of the subject matter, the research program was premised on a systems analysis of the four basic communities of interest involved in the problem (medical, legal, insurance, and general public). The object was to develop a logical, well organized approach leading to (a) identification and comprehensive understanding of the problems, and (b) identification and analysis of alternative solutions to the problems so identified. To the greatest extent possible, the contract research program was limited to quantitative analyses designed to determine the magnitude of problems, and to measure problem area deficiencies in both relative and absolute terms.

The main thrust of the research efforts had to satisfy the following criteria: (a) each project had to deal with a major element of the medical malpractice problem so that taken together they would cover the entire medical malpractice process, and (b) each had to employ a methodology which would allow its completion within the time allowed. The projects were generally oriented toward quantifying (a) the conditions which generate medical injuries, (b) the conditions that generate perception of injuries, (c) the provider-recipient relationship, (d) the process of seeking redress, (e) the activities, and the constraints on those activities, of attorneys assisting parties alleging injury, (f) the operations and characteristics of the insurance industry, (g) existing and alternative adjudication mechanisms, (h) existing and alternative compensation systems.

Some of the studies which appear in this volume have been edited for the sake of brevity or to avoid repetition (e.g. by omitting some case histories or non-essential materials). Nothing substantial has been omitted or changed in any study.

Replicas of the studies as presented to the Commission may be obtained from the National Technical Information Service, U.S. Department of Commerce, Springfield, Va., 22151. An identifying report number is printed on the first page of each study.

MEDICAL MALPRACTICE INSURANCE CLAIMS FILES CLOSED IN 1970

Melvin H. Rudov, Ph.D.
Thomas I. Myers, Ph.D.
Angelo Mirabella, Ph.D.

Summary

The purpose of the survey was to establish the frequency and dollar cost of incidents leading to claim action, and to describe the incidents, patients and health care providers involved in the alleged malpractice events as reflected in insurance records.

The results of the survey showed that:

1. An estimated 12,000 incidents triggered claim file action reaching settlement in 1970, approximately one third of which were warning files rather than true claims. Approximately 40% of the true incidents eventuated in payment to the claimant.
2. The total compensation to claimants was estimated to be 80.3 million dollars, with an additional 10.4 million dollars expend on carrier legal fees and allocated costs.
3. The typical (median) payment for those incidents in which payment occurred was $2000. Payments ranged widely in amount, however, with a noticeable bunching in the $5,000 to $20,000 region as well as the pileup of one half the cases at less than $2,000. Payments in excess of $100,000 were infrequent (3%) but they contributed substantially to the aggregate cost.
4. The typical claim file was established after some initial contact from the health care provider (72%). A single insured party was named in the majority of instances (67%), and derivative claims were filed in just 14% of the cases. The claimant was usually represented by legal counsel (67%). Most claim actions were resolved (i.e., settled or dropped) before reaching the courtroom. Fewer than 10% did reach trial stage. About 29% of cases tried resulted in payment to plaintiff. Resort to alternative forums for resolving malpractice, disputes, e.g. arbitration and medical-legal screening panels, was very rare in the cases surveyed.
5. The injuries alleged to be iatrogenic occurred when patients were being treated for a variety of ailments. Orthopedic surgery, gastrointestinal surgery and gynecological treatment were the most frequent context of alleged malpractice injury. The type of negligence claimed to have resulted in injury was predominantly that of improper treatment (86%), as opposed to failure to diagnose properly. The incidents usually occurred in hospital settings (75%), more specifically located in the surgical suite (39%) or patient's room (34%). Emergency rooms and intensive care facilities accounted for only 13% of the incidents.
6. The severity of injuries sustained was categorized. Consistent with other studies, it was found that the majority of injuries were minor and temporary ones with little or no delay in recovery. However, sizeable numbers of incidents involved more severe injury or fatality. Severity of injury was systematically related to the ultimate disposition and settlement cost of the incident. The more extensively pursued claims tended to involve more severe injuries, and within each disposition category, the higher payment amounts were associated with the more severe injuries. There were a number of exceptions to the trend, however. For example, a number of major injuries and deaths in incidents were described in claim files which were abandoned or did not even reach the formal stage.

7. The patients described in claim files were a representative cross section, insofar as it could be determined, of the general population of health care consumers. Their demographic profile, in terms of age, sex, race, etc., was not unusual.
8. Various types of insureds were named as targets of claim action with distinct outcomes. Hospitals and other institutions were named in 39% of the claims, a substantial number of which were warning files. The median payment when made on behalf of hospitals was $1710. More frequently targeted were the practitioners (59%), with the bulk of these being physicians (49%) as opposed to dentists (7%). Very few allied health workers were named in the claims surveyed. Actions against dentists were characteristically settled at an early stage with a relatively small median payment ($855). In contrast, the median amount of behalf of the physician group was $4190.
9. Some medical specialties contributed disproportionately to malpractice claims, in terms of their number, patient exposure, and disposition and cost outcomes. Most prominent in the malpractice claim arena were the orthepedic surgeons, anesthesiologists, urologists, and obstetrician/gynecologists. Other specialists such as pediatricians, psychiatrists, and opthalmologists represented relatively low risk categories. Several types of practitioners presented anomalous pictures. The internist was an infrequent target of claim action, but exhibited the highest median payment amount when payment took place. On the other hand, the anesthesiologist was very much over-represented in the claim files, but showed the lowest median payment.

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I. Introduction

A major hindrance to the resolution of the nationwide medical malpractice problem has been the lack of credible data reflecting the scope and magnitude of the critical aspects of the phenomenon. For the past several years, statistics appearing in newspaper and magazine articles about this subject have either represented little more than speculation or were repetitious of statistics reported elsewhere, almost always without verification or substantiation. The little credible data that have been available (mainly in the files of insurance carriers) have not been systematically analyzed or widely disseminated, thereby preventing meaningful inquiry into, and analysis of, the salient facets of the malpractice problem.

One of the Commission's prime tasks, therefore, was the accumulation of a fairly comprehensive body of credible statistics and information about the malpractice phenomenon. This was accomplished by means of a survey of the claim files closed by medical malpractice insurance carriers during 1970, from which we sought to develop as complete a picture as possible of the medical malpractice situation as of that point in time. How many claim files were closed? How many medical incidents and how many patients were involved in those claims? How many doctors, nurses, hospitals and other defendants were named? How long did it take the various events to run their course from the time of the alleged malpractice incidents to the final closing of the files? What was the ratio of cases concluded in favor of the defendant to those in favor of the plaintiff? What amounts of money were involved, including the cost of the medical treatments, the possible losses of income of the injured patients, and the costs of defending these claims, including the lawyers' fees involved.

We wished to measure these events against the background of the total number of patients receiving medical care, the number of doctors, nurses, hospitals, and others providing medical care, the number of lawyers specializing in the field of malpractice, and the administrative and other costs of the insurance provided to those concerned. Finally, we sought to obtain the relevant data in a manner that would make it possible to make estimates on a nationwide scale as well as on significant statistical breakdowns (e.g., by medical specialties, age groups, states or regions, etc.).

The following material describes the way in which the study was structured and the results thereof. To understand the meaning of the data collected requires some initial comments on the nature of the malpractice insurance industry and how malpractice claims and potential claims are handled by the industry.

II. Background on the Data Source

When a patient (or his legal representative) notifies an insurance company that he wishes to file a claim against one of the company's insureds, or when a provider (or his representative) notifies the carrier that he has been involved in an incident that might give rise to a claim, the carrier usually opens at least one file on that incident. Typically, any additional insureds named in the claimant's action or registering warning notices are added to the same file. Less frequently (about one-third of the multiple defendant cases), additional insureds generate separate files.

Up to the time that the file is closed, there accumulates a sometimes lengthy documentation of almost every aspect of that case that is relevant. The type of patient and provider that were involved, the nature of the medical complaint for which the patient sought care, the incident giving rise to his claim, and the handling and disposition of his claim are all detailed within this file. By accumulating the information contained within these files, it is possible to make a profile of the incidents and litigants (or potential litigants) involved in the malpractice process.

1. THE SIZE OF THE MEDICAL MALPRACTICE INSURANCE INDUSTRY

The National Planning Association surveyed the medical malpractice insurance industry and was able to locate 68 firms that underwrite medical malpractice insurance in the United States. Both the policy and claim file volumes of most of these firms are quite small. A few firms account for most of the malpractice insurance activity. The 26 firms which agreed to participate in the study were among the largest. Note in Figure 1 that six firms with the highest volume generated about two-thirds of the total claims files under study. The 11 highest volume firms generated about 90% of the files. Although an exact tally of the total market volume was not made, we were led to believe, by the various analyses made and from discussions with knowledgeable members of the industry that we probably tapped close to 90% of the volume of the malpractice market.

Few health care personnel other than physicians (allopathic and osteopathic) and dentists are included in the sample. This is partly due to the fact that the companies that underwrite other health-care professionals were not represented. There appears, however, to be a negligible, volume of malpractice activity among other health-care professionals as compared to physicians and dentists.[1]

2. THE DISTINCTION BETWEEN CLAIMS AND FILES

Almost without exception, in this report the term *claim file* is used in place of *claim*. The distinction is not accidental *and* is important to an understanding of the survey methods employed and the results obtained, since the claim file rather than the claim was the basic source of data. A claim file is simply a collection of records with a single identifying number. It may arise in several different ways, depending upon the particular practice of a given carrier. For example, the file may represent one insured or several insureds associated with a malpractice incident. It may be the only file related to that incident or it may be one of several files, each representing a different "defendant." It may be a "nonclaim," i.e., a file established on the basis of notification by a concerned insured, but without any action on the part of a potential claimant. Finally, it may represent a "nonclaim" which is ultimately settled at the initiation of the carrier.

The actual sampling unit for this survey was the claim file. However, through the use of various analytic techniques (i.e., weighting procedures and frequency cross-breaks), we did attempt to quantify the different conditions described above. For example, we estimated the number of iatrogenic incidents which led to true claims versus those incidents which resulted in warning files.

3. POTENTIAL SOURCES OF BIAS

File Contents

In developing the basic survey instrument, an attempt was made to include every category of information which might possibly appear in the closed claim files. It was subsequently found, however, that some categories of information were frequently unknown. Information on patient characteristics was particularly scarce. Where severe gaps occurred, caution was exercised in using and interpreting the data tallies.

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[1] See "The Malpractice Problem for Non-Physician Health-Care Professionals as Reflected in Professional Liability Insurance Rates," *Infra*, pp. 644 ff.

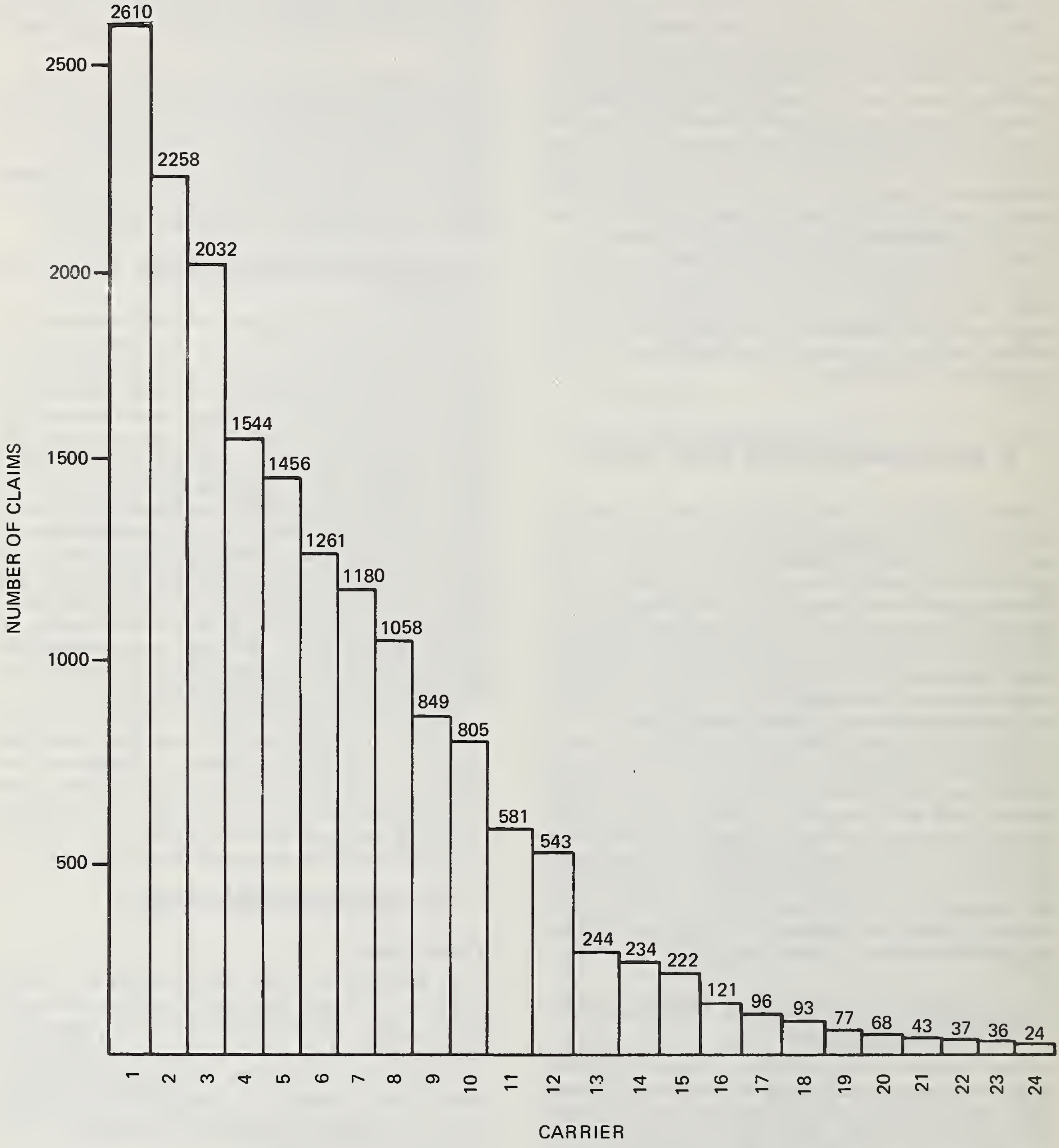

FIGURE 1
MEDICAL MALPRACTICE CLAIMS FILES CLOSED IN 1970 BY COMPANY
AS REPORTED IN A UNIVERSE SURVEY

Interpretation of Data Needs

As will be described later, carrier personnel were used to extract the information from the files. Most of the data required was relatively straightforward, requiring little in the way of inference on the part of the persons extracting the data from the files. Although these personnel were given thorough training and furnished with reference materials and consulting services, there was always a chance that some of the data extraction requests might have been misunderstood. The only evidence that this might have happened was in the reference to a series of data fields describing the results of the carrier's review of the case. The tabulations of these data fields have been omitted in this paper because of our reservations as to their validity.

With the above as general background, the methodology that follows will give additional description of the study's objectives and scope.

III. Methodology

The methodology employed in the closed claim file study was, in some respects, based upon conventional sampling survey techniques. But, in many respects, it evolved from rather unique problems. These included a universe which was not well defined, a sampling unit of interest which could not be measured directly, and a data source which was proprietary. In the remainder of this section, these and other problems are presented and discussed.

1. DEVELOPMENT OF THE SURVEY QUESTIONNAIRE

Preliminary Research

In preparation for the construction of a survey questionnaire, some preliminary research was conducted on the scope of the malpractice phenomenon as seen by the insurance carriers. Approximately 60 firms were solicited to respond to questions related to the following items for the year 1970:

(a) The number of insureds for whom they underwrote medical malpractice insurance, broken down by physicians, dentists, miscellaneous professionals, and hospitals
(b) Total premium income
(c) Total claims files closed
(d) Total incurred dollar loss by above-listed provider categories
(e) Total claims files opened
(f) Disposition of claims in the closed files

The 60 firms were chosen on the basis of a number of inquiries made to knowledgeable individuals and to the firms known to be in the industry. The overlap with both the entries and the size of the list generated by the National Planning Association affirms the thoroughness of the survey.[2]

A total of 31 firms responded to the questionnaire. The bulk of those that declined did so because they felt that their claims volume was too small to make the tabulation meaningful. A few declined for administrative reasons.[3]

A second measure of the consonance of the sample and the universe can be gained by comparing the providers covered by each measure. The companies responding to the survey indicated that they covered 187,000 physicians and 610,000 hospital beds. This corresponds roughly to three-fourths of the nonfederal physicians in health care and to three-fourths of the hospital beds in the United States in 1970. The remaining 25% can be accounted for by the uninsured physicians (estimated at about 7% by an AMA survey) and some hospital-based physicians who are covered by their hospital's policy in the physicians category, and by the self-insured and immunity-protected institutions in the hospital category.

Five of the firms explored had little or no claims activity that year. The remaining 26 firms agreed to participate in the survey. The distribution of closed claims files across these 26 companies is shown in Figure 1. The company names have been deleted in accordance with our agreement with them to preserve their anonymity.

Generating the Survey Instrument

A series of consultations with carrier personnel and brainstorming sessions among Health, Education, and Welfare staff resulted in the draft of an initial protocol.

Two insurance carriers agreed to try out the forms for the purpose of determining whether the data could be abstracted from the files and to estimate the time involved in doing so. Personnel from their staffs abstracted 200 closed claims files for this pilot study. Item analyses were run on a data field basis and most of the items were completed for all of the files abstracted. Filling out the forms took approximately 2.5 hours per file on the average since most of the questions required narrative answers. The instrument that was finally used asked many more questions and took less than thirty minutes to complete.

On the basis of continued delving into the medical malpractice process, staff members derived additional questions of interest, and these were added to the list of data fields on the form. A new form was derived and presented to executives of the 26 firms at a meeting convened to obtain their cooperation in the study. On the basis of their comments, the form was revised. At that meeting, not only was the cooperation of the carriers granted, but their exuberance at desiring to see the data collected resulted in most of them offering to do the work at no cost to the government.

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[2] See "The Medical Malpractice Insurance Market, " infra, pp. 494 ff.

[3] Insurance firms with small claims volume usually do not maintain separate malpractice files nor aggregated data. Getting the requested information could have been onerous for these firms.

An additional meeting was held in which those representatives of the carriers who were to be responsible for the detailed collection activities were present. The purpose of this meeting was to train them in the use of the form. They were each requested to bring five closed claims from their own files and abstracted them at the meeting as part of their training. On the basis of some of the difficulties encountered in this exercise, additional corrections to the form were made. It was at this meeting that the validity and reliability of the newly-developed severity scale was tested. Across the files abstracted, each of the categories was used and almost identical scalings were used by separate abstractors.

2. DATA COLLECTION

The actual extraction of data from the closed claim files was performed by the 26 participating carriers. Ultimately, about 3,000 claims were submitted by the carriers, with the bulk of these (over 60%) from five companies. As completed, survey forms were returned to the Commission for further coding and for preliminary, manual editing.

Coding and Manual Editing

A few of the data entries into the questionnaire items were qualitative. These had to be coded for computer processing. Data on incident characteristics included: (1) diagnosis for which the patient was being treated, (2) associated treatment, (3) negligence alleged, and (4) injury claimed. Translation from the narrative was based upon a classification scheme which combined *International Classification of Diseases, Adapted*, and *Current Procedural Terminology* coding procedures. With the aid of the GSA Worldwide Geographical Location Code Book, incident locations and addresses of patients were numerically coded.

In preparation for keypunching and subsequent data processing, each questionnaire was examined for completeness, accuracy, and consistency of information. Incomplete forms were returned to the carriers for correction or verification.

3. SAMPLING DESIGN

To survey all of the claim files closed in 1970 was not feasible because of their volume and geographical dispersion. Moreover, completing the survey data form for a claim frequently involved collating both claim and policy information files. Thus, a plan for sampling the files was needed.

The Sampling Plan

A plan for a 20% random sampling of claim files was adopted. This was accomplished by pulling those files whose identification number terminated in a '2' or a '7'. This scheme was put into effect after first ascertaining and verifying that the actual numbering of files by the carriers was an unrestricted, random process. Sampling of terminal 2's and 7's in effect provided two 10% samples. This characteristic of the sampling plan was expected to be of value, for example, in deriving reliability estimates of pertinent population parameters.

The intent was to sample the files of claims closed in the calendar year 1970. This sampling, with respect to time of terminal disposition, was obviously needed for a portrayal of outcomes as well as of initiating events. In those few instances where early 1970 files had already been destroyed by a carrier, the sampling was extended into early 1971 records.

Unavoidable Sampling Problems

Some unique methodological problems resulted from the nature of some carriers' claims filing and handling practices since they sometimes underwrote malpractice insurance against varying combinations of individual and institutional insureds. In no way could these problems be averted, since they were the product of behavior intrinsic to the insurance process.

One of these methodological problems was the lack of a simple correspondence of alleged malpractice incidents to the claim files established. A given incident might lead to creation of a single claim file or of multiple files within or across carriers. The result of this situation was that an incident leading to many files had an increased likelihood of being selected. To draw inferences as to the frequency and character of precipitating *incidents* therefore required the development of differential sampling weights, to be described below.

A second, intrinsic complexity of the data set was the possibility of there being one or more insureds involved in a given claim or incident. In effect, this fact dictated the existence of two separate bases of data to be collected: (1) the universe of the incidents, injuries, and patients involved, and (2) the universe of insureds named in claim action. Analytic collation of information across the two domains (e.g., severity of injury and ultimate disposition of claim action) required specific definition of composite indices (e.g., disposition) of total claim action.

4. ORGANIZATION AND REDUCTION OF THE DATA

Resolution of Methodological Issues

Sampling weights had to be developed and two universes of data distinguished before data analysis could proceed.

Derivation of Sampling Weights. The survey design provided for a random 20% sampling of those claim files closed in 1970. As such, the resulting information lent itself to a simple aggregate picture of the claim files universe. Of more fundamental interest to the study, however, was a composite characterization of those alleged medical malpractice *incidents* which triggered these claim actions. The claim and incident universes, however, were not isomorphic. A given incident could have led to the establishment of one or more files in the claim file universe sampled, so that, in effect, precipitating incidents were not uniformly sampled. Those leading to a single claim file had a uniform .20 probability of being sampled; but those incidents leading to a multiplicity of claim files had a proportionately greater than .20 chance of being drawn into the data sample. To transform the information derived from file sampling into a universe of sampled incidents thus required the derivation of incident sampling weights, which would take into account the differing probabilities that incidents would be sampled. Unit probability was assigned to incidents culminating in a single claim. A lower probability was assigned to incident information collated from multiple files, within or across carriers. The actual sampling weight was inversely proportional to the number of claim files established by the reporting carrier for the given incident added to the number of files for that incident believed to have been established by other carriers and directly proportional to the total number of files for an incident which turned out to end in a '2' or a '7'.

Identification of Two Universes of Data. An intrinsic feature of malpractice cases is that there may be one or more insureds named as a target of claim action. This fact establishes for this study two separate bases of aggregated data—one having to do with claim action for an alleged injury to a given patient, and the other concerning the distribution of those practitioners and health-care institutions alleged to have contributed to an injury. For purposes of summarizing descriptive information pertinent to each of these, the fact of dual universes posed no problem. The properties of patients and their injuries can simply be aggregated across the incidents base (making use of the sampling weights to equalize the opportunity of each incident's selection into the data). Similarly, the characteristics of health care agents involved in malpractice claim action can be summarized (making use of a somewhat different set of weights to equalize sampling opportunity). The possibility of confusion arises, however, for information variables, such as claim action outcome, which are relevant *both* to the incident as a whole and to separate actions against individual insureds. Settlement costs or payment to plaintiff, for example, can be summed over all insureds to represent the entire claim action or considered separately as payment to the plaintiff on behalf of each insured party. For other outcome measures, such as disposition, there is no simple additivity between insured and incident domains. And in fact, the dispositions of claim action against a series of insureds may not always be the same. Action against one of the insured parties may reach the litigation stage, whereas action against another insured named in the same incident claim may be dropped or settled before it reaches the suit stage. We have chosen, in the example of disposition, to define disposition of an incident as that which reached the most advanced stage for the claimant. Needless to say, the frequency and distribution of incident dispositions, so defined, is quite different from the array of separate dispositions accorded actions against all named insureds. There are information variables other than outcome for which it is useful to define single indices to span all of the insureds involved. Examples are (1) multiplicity of insureds, as such, and (2) inclusion of practitioners of the various types or of institutions among the insureds named in claim action. In summary, the existence of separate universes of data for incidents and insureds led to separate handling of informational analyses and a need to construct careful definitional bridges when interrelating variables of these two universes.

Data Reduction. Data processing requirements of the study were quite straightforward. After careful manual editing of the questionnaire forms, the information was keypunched onto a basic series of eight IBM cards (augmented by an additional five cards for each additional insured party). Additional editing was specified for the data within each incident to include checking the completeness of the card set, the presence of inadmissible punches in each data field, and consistency of entries across fields (e.g., progression of dates for sequential events). Indicated corrections were repunched and substituted in the data array. Also specified was the addition of certain scores to be derived from the basic information obtained on the questionnaire, e.g., the sampling weights discussed and various time interval scores. Finally, the corrected data set was to be formatted properly on disc before executing the desired computer processing.

Three Types of Analyses. The first set of analyses was to provide sample-weighted summaries, on a variable-by-variable basis, of data pertaining to incidents and patients. The purpose was to provide a profile, for comparison with appropriate baseline expectations, of the types of patients involved in claim action, the nature of injuries and alleged negligence sustained, and the source and mode of claim initiation.

The second set of analyses was designed to provide properly weighted descriptions of those insureds named as targets of negligence allegations. Of chief interest in this regard were the distributions of practitioner insureds by medical specialty, certification and other biographical categories, and of institutional insureds in terms of approvals, facilities, and the like.

The third set of analyses concerned the interrelational cross-tabulation of information linking both incident and insured variables to various indices of outcome, such as disposition and settlement cost. Appropriate to the two universes of data, incidents and claims, such cross-tabulational runs were to be performed separately. The principal purpose of these operations was to identify those attributes of patients, defendants and incidents disproportionately associated with more severe and costly outcomes.

IV. Results

The findings to be presented are preliminary because not all of the analyses had been carried out at the time of this writing. For the most part, the results are based upon about 50% of the approximately 3,000 cases that were collected, and within plus or minus 10% are those to be anticipated for the entire sample and for the universe of 1970 malpractice action in the insurance industry.

Some distortion may result from the fact that the findings presented are based, except as noted, on unweighted treatment of the data. We have applied sampling weights in deriving estimates of the total number of malpractice incidents closed in 1970 and of their aggregate settlement costs. Use of corrective weights is crucial to accuracy in these instances, but the other results presented are probably very slightly altered, if at all, by the absence of weighting corrections.

Unfortunately, there are gaps in the range of variables for which we have preliminary findings. Most conspicuously absent are the various time interval variables descriptive of the time taken between, for example, the filing of a claim, its disposition, and receipt of payment.

The presentation of the findings is organized into three sections: (1) the overall frequency and cost of claim-related incidents, (2) the nature of the incidents and their outcomes, and (3) the types of insureds involved in claim action and the outcomes.

1. OVERALL FREQUENCY AND COST OF CLAIM-RELATED INCIDENTS

The overall severity and magnitude of the alleged medical malpractice problem was evaluated by two indices derived from the 1970 closed claim study of insurance operations: the estimated number of incidents which occurred, and the total costs of settlement with the injured parties.

We estimate that approximately 12,000 incidents triggered claim action reaching settlement in the calendar year 1970 among the 26 insurance companies we sampled. This estimate, of course, does not represent all malpractice-related injuries which could have attained disposition in 1970 but, rather, only those that caused a carrier to establish a claim file. The true number of claim-inducing incidents would be somewhat larger than 12,000, since the study surveyed carriers representing only about 90% of the industry.

Not all incidents occasioning the preparation of a claim file, of course, resulted in remuneration to the allegedly injured party. Those claims resulting from incidents that did lead to payment to the claimant, however, added up to a total compensation of approximately $80.3 million. Again, this cost estimate may be an underestimate of the true total for the industry as a whole.

The total dollar cost of malpractice incidents includes many elements in addition to the remuneration of injured parties. Plaintiff legal and other costs, loss of income not fully compensated, etc., are additional sources for which we could not collect information. We did obtain information from the carriers, however, as to their allocated and legal costs involved in each claim. The aggregate legal and allocated costs associated with claims closed in 1970 totaled $10.4 million. This figure is an underestimate of the true total since not all carriers apportioned their allocated costs to claims with the same degree of accounting sophistication.

2. CHARACTERISTICS OF INCIDENTS AND THEIR OUTCOMES

One set of analyses concerned the type of incidents and their outcomes as could be judged from the universe of (unweighted) claim file information. Characteristics of the claim, the injury, and the patient involved in the claim were obtained directly from the information blocks on Form A of the questionnaire. Similarily, indices of outcome were derived for the incident as a whole. For example, total payment to claimant on behalf of all insureds was used to measure incident settlement cost, and the farthest stage of the processing or litigation of the claim against any insured was used to describe the overall claim resolution.

The following section summarizes information relative to the claim, the nature of the incident or injury involved, and the characteristics of the claimant parties. This section also considers the overall outcome of incidents sampled in terms of economic impact, disposition, and their interrelationships.

Characteristics of Claims

Source of first claim contact. Initial contact was made by the patient or his agent in just 24.2% of the cases, and of these, 20.2% were from the patient's attorney. In about 72% of all cases, the health-care provider initiated contact. The distribution of responses was as follows:

Source	Percent of Cases Where Known
Practitioner	30.6
Practitioner's Attorney	1.3
Institution	24.4
Medical Society	15.4
Patient	3.3
Patient's Attorney	20.2
Patient Estate or Friend	0.7
Other	4.1
	100.0

Number of insureds named. In 62% of the claims, a single insured party was named as responsible for the negligence alleged. Two insureds were specified in 17%, and three insureds in 10% of the cases.

Derivative claims. One out of seven cases involved a derivative claim. The derivative claimant bore the following relationship to the primary claimant:

Type of Claimant	Percent of Cases Where Known
Spouse	54.6
Parent	32.2
Child	6.6
Other	6.6
	100.0

A total of 96% of the derivative claims were made against the same defendant as that of the primary claim.

Joint Plaintiffs	Percent of Cases Where Known
Spouse	63.9
Parent	25.2
Child	7.8
Other	3.1
	100.0

Involvement of plaintiff and referred attorneys. In 66.8% of the cases a plaintiff's attorney was involved. In 13.5% of the cases a referred attorney was involved.

Month of file openings. Files were opened homogeneously throughout the year. There was no apparent monthly or seasonal fluctuations.

Time to disposition. A rough measure of the time required for final disposition of a claim was obtained by classifying cases as to the year of the first incident (since claims were closed in calendar year 1970).

Time, Incident to Closing	Year of First Incident	Percent of Cases Where Known	Cumulative Percent of Cases Where Known
less than 1 year	1970	18.6	18.6
1 year	1969	23.3	41.9
2 years	1968	15.9	57.8
3 years	1967	11.7	69.5
4 years	1966	10.9	80.4
5 years	1965	7.1	87.5
6 years	1964	5.5	93.0
7 years	1963	3.1	96.1
8 years	1962	1.7	97.8
9 years	1961	0.7	98.5
more than 9 years	1960 or earlier	1.5	100.0
		100.0	

In the median case, about two years elapsed between the first medical incident and claim closing. More than 90% of the claims were closed within six years of the incident. For 1.5% of the claims, the interval dragged beyond nine years.

Alternative forums. Information was sought as to the frequency and outcomes with which cases were reviewed by Arbitration, Screening, and Medical Society review panels. Arbitration took place in less than 1% of the cases. Of the seven Arbitration cases, five were decided in favor of the claimant. Screening was also used in less than 1% of the cases. Of the eight cases reviewed by a Screening Panel, three resulted in a recommendation for the claimant. Panel review by a Medical Society occurred in 11.5% of the cases. For those 140 cases whose recommendation was known to the carrier, about 46% of reviews were in favor of the claimant.

Characteristics of Injuries

Treatment being received. Patients were being treated for a variety of ailments at the time the alleged negligence occurred. Among the more frequent of ongoing treatments were:

Type of treatment		Percent of Cases Where Known
Surgical		57.2
Orthopedic	19.0	
Cardiovascular.	1.8	
Gastrointestinal. . . .	11.5	
Gynecological	10.3	
Obstetrical	5.1	
Other surgical	9.5	
Medical		20.5
Psychiatric	1.5	
Cardiovascular	1.4	
Other medical	17.6	
Radiological		6.1
Diagnostic	5.2	
Other radiological .	.9	
Pathological		1.6
Anatomic	1.1	
Other pathological.	.5	
All Other Treatment		14.6
Emergency	5.8	
Vaccinations	1.2	
Other treatment . .	7.6	
		100.0

Nature of alleged negligence. The variety of injuries ascribed to malpractice is too broad to permit simple summarization. The major categories of alleged negligence were twofold: failure to diagnose a condition properly, and improper treatment of a correctly diagnosed condition. The overwhelming majority of incidents (86%) leading to malpractice claims involved an allegation of *improper treatment.* Only one in seven incidents claimed a failure to diagnose.

Degree of emergency involved. Non-emergency conditions where the medical treatment was required constituted the bulk of cases (66.3%). In 20.6% of the cases an emergency condition existed, and in 2.5% of the cases no treatment was given. Elective treatment conditions constituted 10.7% of the cases.

Severity of injury sustained. Although of diverse character, the injuries precipitating malpractice claims were classifiable according to a categorical scale of severity of injury.

The severity of injury is a measure of the amount of harm alleged by the plaintiff. As such, it has a potential use as a dependent variable for measuring whether awards and settlements are equitable, for estimating the cost of a medical injury compensation system, for evaluating the general quality of care within the nation, or for understanding most other measures of the medical malpractice process. However, the degree of injury is not a unidimensional concept, but is one that has at least four dimensions:

(a) *Severity of Injury*—This is a difficult concept to deal with. The ordinal properties of some injuries are obvious. For example, few people would disagree that to lose an arm represents a higher degree of severity than to lose a finger. However, determining which is the higher degree of severity (excluding economic considerations) between a case in which a person ends up in a vegetable state and one which results in death is a highly subjective judgment indeed.

(b) *Recovery*--The concept of recovery has three dimensions,, each providing one of the three remaining dimensions described above. They interrelate with each other in a complicated way.

  (1) *Permanency.* Either there is a recovery from an injury or the injury is permanent. However, the other subconstructs interact with this dichotomy.

  (2) *Amount of Recovery.* Recovery can be total or partial. Either the injury is viewed as a permanent one in which the focus is on the residual effects following partial recovery, or it can be seen as a temporary one in which the focus is on the amount of improvement. Where there is partial recovery it can also be viewed as a combination of temporary injury (that portion of the injury from which there is some recovery) and a permanent injury (the residual). This conception requires that two measures be used, thus reducing the utility of the resultant scale as a dependent variable.

  (3) *Time Course.* Recovery must occur over some period of time.

To view these subconstructs with their interactions, then, some patients recover totally from their injuries, some do not recover at all, and some recover partially. Those who recover partially may recover anywhere from a slight to an almost total amount. Where there is any recovery at all, there is some period of delay over which the recovery takes place. Trying to place each of these possibilitiies into a unidimensional scale requires that these considerations not receive separate treatment.

The result was a hybrid scale made up of a series of nominal and ordinal scales. The first scale is one for no physical injury. This is a one-point scale used where there is an economic loss or psychological fright. Although this could have been a multiple point or ordinal scale, cases of this type were expected to be too infrequent to merit allocation of much of our scale space to it. The second scale is a three point scale used for temporary injuries in which the degree of injury and sometimes delay in recovery were varied or covaried. The third scale is a four point ordinal scale used for permanent injuries in which the degree of injury and sometimes the delay in recovery were varied or covaried. The fourth scale is a single point scale for cases in which death occurred.

The bulk of the cases fell into the *temporary injury* categories (50.9%). Some type of *permanent injury* was sustained in 18.7% of the cases. Injuries leading to *death* constituted a similarly sizable group of 18.3% of the cases, while, at the other extreme, the *no physical injury* category (which included psychological-only injuries) comprised 12.1% of the total.

Severity of Injury	**Percentage of Incidents**
1. No Physical Injury	12.1
2. Temporary - Insignificant	20.8
3. Temporary - Minor	17.6
4. Temporary - Major	12.5
5. Permanent - Insignificant	9.1
6. Permanent - Minor	7.1
7. Permanent - Major	1.6
8. Permanent - Grave	0.9
9. Death	18.3
	100.0%

Facility where injury occurred. The facilities in which the alleged events occurred were mostly hospitals, with the bulk of the remaining cases arising out of injuries incurred in the practitioner's office. The distribution of the facilities where the incidents occurred was:

Facility	**Percent of Cases Where Known**
Hospital	74.6
Office	20.3
Home	1.7
Nursing Home (and ECF's)	0.6
Outpatient	0.1
Other	2.7
	100.0

The *within-hospital site* where the incident occurred was broken down more specifically. The surgical suite of the hospital was most frequently the site of incidents (38.7%), followed by the patient's room (33.8%) and the emergency room (11.8%). These three locations within the hospital accounted for over 84% of the injuries. An additional 2.9% occurred in the X-ray facility, and the labor and delivery rooms contributed an additional 2.8%. It is interesting to note that intensive and cardiac care units contributed only 1.1% of the cases.

TABLE 1

Severity Scale	Amount of Recovery	Severity of Injury	Delay in Recovery	Examples
1	No Physical Injury	Insignificant	Not Applicable	Psychological, fright
2	Temporary Injury	Insignificant	No delay	Lacerations, bruises, contusions, rash, broken caps of teeth, minor allergic reaction
3	Temporary Injury	Minor	Slightly Delayed	Operation induced infection, mis-set fracture, failure to diagnose glass in cut, staph infection from lack of antibiotics
4	Temporary Injury	Major	Significantly Delayed	Burns, broken ankle from fall, surgical material left, major drug side-effect, severed nerve or tendon
5	Permanent Injury	Insignificant	Not Applicable	Loss of fingers or toes, foot drop, withered arm, loss of teeth, scars
6	Permanent Injury	Minor	Not Applicable	Deafness, loss of limb, loss of eye, loss of one kidney or lung, gross deformity of limb
7	Permanent Injury	Major	Not Applicable	Paraplegia, blindness, loss of two limbs, brain damage, etc.
8	Permanent Injury	Grave	Not Applicable	Quadraplegia, severe brain damage, comatose, lifelong care, etc.
9	Death	Not Applicable	Not Applicable	

Health care cost coverage. The principal source of coverage for the costs of health care being received at the time of the incident was as follows:

Coverage	Percent of Cases Where Known
Health Insurance	47.9
Self Payments	25.9
Medicare	11.7
Workman's Compensation	7.7
Medicaid	1.2
Other	5.6
	100.0

Contribution of others to injury. The question was asked whether the carrier believed that someone not named in the claim contributed to the injury. In 86% of the cases the answer was "no." Of the remaining 14% of the cases, another practitioner was named in 4.7% of the cases, and an R.N. was named in another 2.5%. The patient as a contributor to his own injury was named in only 1.4% of the cases.

Characteristics of Claimants. Information about the patients involved in malpractice claims was requested in order to learn whether particular categories of patients were more frequently associated with claims than would be expected on the basis of their consumption of health care services. The baselines obtainable were approximate, typically being a single-year census of health care services delivered to patients of various demographic descriptions, whereas patients in the closed claim study were involved in incidents spread out over a 10-year span. Thus, a more accurate baseline would have required some pooling of separate evaluations within each of the several years during which the injurious incident took place. But a comparison of patient attributes with the single-year census figures provided a useful, if approximate, evaluation.

Age of patient. The age of the injured patient at the time of the injury was known to the carrier in 89% of the cases. Of these cases, 22.6% concerned patients over 60 years of age, 33.7% were between the ages of 40 and 59, 29.4% were between the ages of 20 and 39, and 14.4% were under 20 years of age.

Of particular interest is the percentage of persons of retirement age (i.e., of age 65 and greater), estimated to be 17% or 18% in the closed claim survey. This proportion is roughly the same as the 17.4% in this same age bracket who were discharged from short-stay hospitals in 1969, but somewhat higher than the 13.6% of physician visits in the same year by patients in this age group. Thus, older persons require more health care than their numbers (9.5%) in the population would indicate, but there is no strong basis for believing that such individuals are more prone to involvement in malpractice claims than the volume of their hospitalization would suggest.

Marital status. The marital status of patients involved in malpractice claims was reported in most instances (83%). The majority of these persons were married (64%); about 24% were single; 7% were widowed; and 5% divorced or separated.

Race of patient. Information as to race was not available in 54% of the closed claim files. Of those cases where race was reported, 86.3% were Caucasian, 9.6% were Black, 2.6% were Chicanos, 0.5% were Oriental, and 0.3% were American Indian.

Health care breakdowns available for the year 1969 were limited to white or non-white categories. Percentages of physician visits (89.8%) and of short-stay hospitalizations (87.4%) for whites in 1969 were not greatly different from the 86.3% Caucasians obtained in the present survey. The congruence seems even closer if Chicanos were classed as "white" in the medical care census cited.

Sex of patient. Women were involved as patients in 58% of the closed claims, and men were involved in 42%.

Although this preponderance of women in malpractice incidents exceeds their proportion (51.8%) in the population, it closely matches the extent to which females are consumers of health care services (57.8% of the 1969 physician visits were made by women, and 60% of short-stay hospitalizations in 1968-69 involved women). Thus, sex of the patient appeared to have little role in determining malpractice claim actions.

Head-of-household status. Information was available in 64% of the cases. Of these instances, about 33% of the cases involved heads of households.

Number of dependents. In most instances (70%), the number of a patient's dependents was unknown to the carrier. Where there was some indication, 60% of the cases had no dependents, 12.6% had one dependent, 9.1% had two dependents, 7.0% had three dependents, and 11.3% had four or more dependents.

Claimant annual income. This information was not available to the carrier in most cases (69%). About 60% of the patients were reported as unemployed and listed as having no income. Of those listed as having some income, 31.6% were reported to have less than $5,000 income per annum, 26.4% were in the $5,000 t0 $7,000 range, 21.3% in the $7,000 to $10,000 range, 12.1% in the $10,000 to $15,000 range, and 8.6% in the above $15,000 category. The income distribution for closed claim patients was fairly similar to that of patients in 1969 undergoing short-stay hospitalization.

Occupational status of patient. The majority of patients surveyed in closed claim files were housewives or other non-wage earners. The distribution by occupational status was:

Occupational Status	Percent of Cases Where Known
Employed	39.0
Housewife	27.7
Non-Wage Earner	18.3
Retired	7.9
Unemployed	3.9
Self-Employed	3.2
	100.0

Outcomes of Alleged Malpractice Incidents

The study examined files closed in 1970 and therefore some type of disposition was made in each case. A file may have been closed without ever having reached an explicit claim stage (including the so-called "warning file"). It may have reached a claim but not a suit stage; or it could become a suit which was subsequently settled either before, during, or after trial. Payment or nonpayment to the claimant could have occurred at any of these stages. The resulting two-by-five classification of disposition[4] has been used for the analyses to be summarized in this section.

As mentioned above, a given incident could lead to claim actions against several insured parties with varying results. To characterize the outcome of an incident as a whole thus required some means of representing several perhaps diverse outcomes. In this section, we have chosen the most advanced disposition as the index of disposition for each incident. Since payment is an important ingredient of disposition, the index used was the most extensive claim action leading to payment in those cases where at least one payment was made. Thus, for example, pre-trial settlement of a suit was utilized in preference to a suit dropped during trial as a descriptor of the disposition of a case involving these two separate outcomes.

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[4] Dispositions with payment in the pre-claim, pre-suit, suit before trial, suit during trial, and suit after trial categories were defined by questionnaire Form B, block 19 responses of 21, 22, 23, 24, and 25 or 26, respectively. Corresponding categories but with no payment were defined as responses of 11, 12 or 13, 14 or 15, 16 or 17, and 18, respectively.

The total amount of payment to the claimant for the incident, from all carriers and on behalf of all insureds, was used as the measure of settlement cost in the analyses within this section.

The severity of injury scale described above was also used in this section as an index of the injury sustained. A number of descriptive analyses were made of the disposition, settlement cost, and severity of injury involved in the cases processed. In the case of settlement cost, sampling weights were applied to correct for unequal opportunities with which an incident was sampled in the claim file survey. The remaining analyses employed unweighted claim file frequencies.

Payments to Plaintiffs. It was estimated above that an aggregate payment cost of approximately $80.3 million was entailed by the 12,000 incidents for which claim files were closed in 1970. Actually, about 7,200 incidents or 60% of the total number of incidents resulted in no payment at all to the claimant.

To portray the amounts paid to claimants of the typical "malpractice" incident requires a breakdown of incidents according to the amount of payment.

Total Amount Paid Per Incident, In Dollars	Percent of Incidents	Cumulative Percent
1 - 999	37.1	37.1
1-499 21.1%		
500-999 16.0%		
1,000 - 1,999	12.3	49.4
2,000 - 2,999	10.1	59.5
3,000 - 3,999	3.0	62.5
4,000 - 4,999	2.7	65.2
5,000 - 19,999	23.4	88.6
1 - 19,999	88.6	88.6
20,000 - 39,999	5.3	93.9
40,000 - 59,999	1.3	95.2
60,000 - 79,999	1.0	96.2
80,000 - 99,999	0.8	97.0
100,000 and up	3.0	100.0

As can be seen from the table, three-fourths of the incidents were closed with less than $10,000 paid, and about one-half with less than $2,000. The median amount was $2,000. The distribution shows higher concentrations at the low region of the payment cost scale. The very high payment was infrequent—about 3% exceeded $100,000.

Disposition of Claims. The relative percentage of incidents leading to claims reaching disposition of the various types is shown in Table 2.

More than one-third of the incidents (39.1%) did not reach the claim stage. Most of these involved incidents which prompted an insured party to contact his carrier, but which did not lead to any action by the potential claimant. In fact, fewer than 10% of the pre-claim, no-payment incidents were initiated by the injured party or his agent. Some of the pre-claim cases, however, were settled with payment at the carrier's initiative.

Most of the incidents (about 65%) were disposed of before suit action was initiated, and fewer than 10% of the cases actually went to trial.

The ratio of payment varied markedly with disposition stage, with pre-claim and pre-suit dispositions at a ratio of .28 and .33, and both before-trial and during-trial dispositions at .64. Payment to plaintiffs in suits litigated, however, occurred in 29% of the cases. These differences clearly reflect the practice of carriers in seeking to settle legally meritorious claims prior to their reaching trial.

The typical cost of settlement also varied with stage of disposition. Pre-claim settlements with payment had a median payment of $500. Pre-suit incidents had a median payment of $1,000. Suits reaching before-trial, during-trial, and after-trial settlement, respectively, had median settlements of $4,000, $2,450, and $12,700. Since so many settlements occur at round numbers such as $500 or $1,000, median payments frequently come out at these even numbers. A more detailed view of this cost breakdown by disposition stage is shown in Table 3.

No settlements in the larger amounts are made for pre-suit claims. For claims reaching the suit stage, the relative proportion of very high payment increases steadily with the extent of litigation. More than one-fourth of settlements after trial were for $100,000 and up.

Severity of Injury, Disposition and Cost. One set of analyses addressed the question as to whether amount of payment reflects the severity of injury. Within each of the disposition stages, separately, the number of claims paid and not paid was found for each level of severity. The tetrachoric correlations ranged in value from .49 to .73, and each was statistically significant at the .001 level except for the after-trial category, which had a relatively low number of cases. Thus, considerable support was obtained for the positive association of payment cost with the severity of injury sustained by the claimant.

TABLE 2

PERCENT OF INCIDENTS CONCLUDED AT VARIOUS STAGES OF RESOLUTION[5]

	Pre-Claim	Claim, Pre-Suit	Suit, Before-Trial	Suit, During-Trial	Suit, After-Trial	Total
Payment	11.0	8.6	16.6	2.1	1.7	40.0
No Payment	28.1	17.2	9.4	1.2	4.1	60.0
Totals	39.1	25.8	26.0	3.3	5.8	100.0
Ratio of Payment	$\frac{28}{100}$	$\frac{33}{100}$	$\frac{64}{100}$	$\frac{64}{100}$	$\frac{29}{100}$	$\frac{40}{100}$

TABLE 3

CUMULATIVE PERCENT OF INCIDENTS WITHIN DISPOSITION CATEGORIES

Total Settlement Cost of Incident, in Dollars	Pre-Claim	Claim, Pre-Suit	Suit, Before-Trial	Suit, During-Trial	Suit, After-Trial
1 - 499	49.5	31.4	3.3	0.0	0.0
500 - 999	66.1	49.9	18.6	15.3	4.6
1,000 - 1,999	78.5	71.1	30.7	34.4	4.6
2,000 - 2,999	89.4	75.7	42.4	52.8	4.6
3,000 - 3,999	89.4	75.7	49.2	56.6	8.2
4,000 - 4,999	90.4	77.5	54.3	56.6	17.4
5,000 - 9,999	100.0	97.4	70.7	56.6	30.0
10,000 - 19,999	100.0	100.0	83.8	74.7	56.5
20,000 - 39,999			95.0	86.9	65.7
40,000 - 59,999			97.6	86.9	69.4
60,000 - 79,999			98.1	90.7	72.4
80,000 - 99,999			99.4	93.2	72.4
100,000 and up			100.0	100.0	100.0

Cases resolved prior to the filing of a suit usually did not involve permanent or major injuries, regardless of whether the action resulted in payment; but the majority of claims reaching the suit stage did involve injuries with greater degrees of severity.

3. CHARACTERISTICS OF DEFENDANTS AND OUTCOMES

Attention is turned in this section to the results pertaining to the types of insureds involved in claim action and the outcomes of these actions. At this point the base unit of data becomes the defendant, whereas before, it was the incident. Now the analyses are oriented toward the aggregation of individuals and institutions named in malpractice claim actions. With respect to measures of outcome, the present section uses payment to plaintiff on behalf of the particular insured as the definition of payment amounts. Claim disposition simply refers to the disposition accorded claim action against the particular insured.

OUTCOME STAGE OF DISPOSITION AND SEVERITY OF ALLEGED INJURY DISPOSITION CATEGORIES

Outcome Severity Levels	Pre-Claim	Claim, Pre-Suit	Suit, Before Trial	Suit, During Trial	Suit, After Trial
Payment					
Severity Levels 1 - 3	77	66	34	15	21
Severity Levels 4 - 9	23	34	66	85	79
Total	100%	100%	100%	100%	100%
No Payment					
Severity Levels 1 - 3	63	62	41	40	31
Severity Levels 4 - 9	37	38	59	60	69
Total	100%	100%	100%	100%	100%
All Claims					
Severity Levels 1 - 3	70	64	37	27	26
Severity Levels 4 - 9	30	36	63	73	74
Total	100%	100%	100%	100%	100%

Characteristics of Insureds

Limits of Liability The following table describes the extent to which insureds are protected financially against malpractice claims. The most noteworthy fact about these data is that about 92% of the insureds are covered for at least $100,000/$300,000 ($100,000 per incident, $300,000 per year). Overall, this appears to be more than adequate coverage in view of the fact that the average claim (where payment is made) is settled at a median cost of $2,000, and just +% of the payments are for more than $100,000.

Limits of Liability		Percent of Insureds
Under	$100,000	7.7
	100,000/300,000	32.7
	200,000/600,000	12.7
	500,000/1,000,000	11.9
	1,000,000/1,000,000	4.8
	1,000,000/3,000,000	1.4
Over	1,000,000/3,000,000	3.3
Other		25.5
		100.0

Prior "malpractice" history. A potentially important question for prevention of medical misadventure is whether or not there is a substantial number of repeaters. Are there some insureds who are more prone to malpractice than others? There is some evidence that the answer to this question may be "yes," since 70% of the insureds (where known) had one or more previous claims against them. However, individuals have not yet been separated from hospitals with respect to this question and, thus, this point cannot as yet be fully evaluated.

The types of insureds. Information obtained as to the type of insureds indicates that the population of insureds is almost exclusively practitioners and hospitals (95%). The remaining 2% are about equally divided among nurses, pharmacists, and technicians.

Type of Insured	Percent Where Known
Practitioner	58.8
Hospital	38.9
Allied Health Workers	2.3
	100.0

Speciality of practitioner. About 90% of the practitioners are physicians (MDs or DOs). The remainder are DDSs. Claims by medical specialty are shown in Table 4.

The claims-by-specialty table also shows comparisons of the obtained percent for each specialty in the claim study with two exposure baselines: (1) the relative frequency of physicians in practice, and (2) the relative percent of total patient contact (office and hospital visits.) It can be seen that General Practitioners were over-represented in claim actions, relative to their number, but their likelihood of being targeted for claim action was in close harmony with their relatively high volume of patient contact. At the other extreme, Psychiatrists were under-represented in claim action on a numerical basis, but their numbers closely resembled their relatively low rate of contact with patients.

Medical Specialists, in general and in discrete categories, were under-represented in claim actions. In the case of Internal Medicine and Pediatric specialists, they were also less frequently named than their volume of patient contact would lead one to expect.

Over-representation in claim action was conspicuous for the Surgical Specialties and for Anesthesiologists. The latter were named more than twice as frequently as their census percent would suggest and more than six times as often as their standing in the patient contact measure. The findings thus confirm that medical specialties differ markedly in the attendant hazard of being named in medical malpractice action.

TABLE 4
MALPRACTICE CLAIMS BY MEDICAL SPECIALTY

Specialty	Percent in Claim Files	Compared* with the Percent	in Physician Census**	Compared* with the Percent	of Patient Contact***
General Practice†	25.0	Over	19.4	Same as	25.7
Medical Specialties	11.7	Under	25.9		
Internal Medicine	6.9	Under	14.0	Under	13.1
Pediatrics	2.3	Under	6.0	Under	6.7
Others	2.5	Under	5.9		
Surgical Specialties	42.3	Over	28.8		
General Surgery	14.8	Over	10.0		
Obstetrics/Gyn.	8.3	Over	6.3	Over	6.4
Opthalmology	2.1	Same as	3.3		
Orthopedic Surg.	8.8	Over	3.2		
Urology	2.8	Over	1.9		
Others	5.5	Same as	4.1		
Other Specialties	21.0	Under	25.9		
Anesthesiology	7.9	Over	3.6	Over	1.3
Psychiatry	2.3	Onder	7.1	Same as	3.0
Radiology	4.8	Same as	3.5	Under	6.3
Others	6.0	Under	11.7		

*The χ^2 statistical test was to compare the actual number with the number of physicians expected on the basis of Census or Patient Contract. The code "Over or "Under" denotes a difference significant at the .05 level of confidence in the indicated direction.

**Physician Census percents were derived from the Table on Non-Federal Physicians in the "Distribution of Physicians in the United States," American Medical Association, 1971.

***Patient Contact percents were derived from a combination of Census percents and patient visits as given in "The Profile of Medical Practice," American Medical Association, 1972. Specialties for which there was no information are left blank.

†The activities of general practitioners cover the entire spectrum of risk since one may do no surgery while another may do major surgery. The conclusions that can be drawn from the claims experience of general practitioners are therefore limited.

Type of practice. The majority of practitioners named in claim action were engaged in individual practice. The distribution with respect to type of practice was:

Type of Practice	Percentage
Individual	59.1
Partnership	24.6
Group Practice	8.4
Institutional	3.8
Industrial Practice	0.5
Medical Corporation	2.1
Other	1.5
	100.0

Board certification. Approximately 60% of the insureds were reported to be board certified. At the present time we have no further breakdown of this information as to type of practitioner and specialty.

Premium classification of risk. Information was obtained in over 80% of the cases as to the premium classification of the M.D. practitioners. Not surprisingly, a comparison of the obtained distribution descriptive of claim files with the relative frequency in the physician population revealed disproportionately high frequencies in the higher risk categories. Observed and expected percentages were as follows:

Premium Risk Category	Percent in Claim File	Percent in Physician Population	Ratio of Percent in Claim File to Percent in Population
1	32.4	47.7	.68
2	13.1	11.7	1.12
3	7.1	15.1	.47
4	17.6	10.7	1.64
5	29.8	14.8	2.01
	100.0	100.0	1.00

Age of individual insureds. The age of the insured at the time of the incident was known in more than 85% of the cases:

Age Category	Percent of Insureds Whose Age Was Known
20 - 29	2.7
30 - 39	29.3
40 - 49	36.9
50 - 59	17.8
60 - 69	10.5
70 - 79	2.8
	100.0

No precise comparison could be made of this distribution with baseline values, since a small number of nonphysician insureds were included in the tabulation. However, it was noted that this age distribution did deviate in the direction of the young from the age distribution for the physician population.

Sex of insureds. In almost every case, the sex of the insured was reported. The overwhelming majority (96%) were male. This preponderance of maleness in malpractice claim action significantly exceeded the proportion of males (92.9%) in the physician population.

Was the patient treated by insured after recognition of injury? An interesting question in the malpractice field concerns the extent to which the practitioner-patient relationship persists beyond the patient's recognition of the injury. Treatment continued in 20.8% of cases where the answer to this question was known to the carrier.

Characteristics of hospitals named in claim action. As mentioned above, roughly one-third of the claims were made against hospitals. Data were collected on the approvals and facilities provided by these hospitals, with the following results:

Hospital Approval	Percent of Hospitals Named with Approval/Facility
JCAA	90.9
Cancer Program	31.0
Residency	42.5
Internship	36.3
Medical School Affiliation	16.7
Nursing School	30.8
Council of Teaching Hospitals	16.5
Blue Cross	94.2
Medicare	94.2
American Osteopathic Ass'n.	2.5
Osteopathic Internship	2.6
Osteopathic Residency	2.1
Hospital Facility	
Dental	43.6
Pharmacy	90.8
Premature Nursery	65.4
Outpatient Department	58.7
Emergency Department	88.0
Post-Op Recovery	90.2
Hospital Auxiliary	80.5
Home Care	11.6
Organ Bank	3.9
Renal Dialysis, Inpatient	22.4
Renal Dialysis, Outpatient	16.6
Initial Therapy	74.7
Volunteer Services	59.5
Closed Circuit TV	30.5
Intensive Care	73.9
Self-Care Unit	10.9
Family Planning	10.4

The percentage of hospitals with the various approvals and facilities named in claim actions is very high. The values shown substantially exceed their incidence in the hospital population. Obviously, this cannot be interpreted as evidence of unusual quality of hospitals involved in malpractice, however, without further information as to the size and other characteristics of the hospitals involved in claim action. It is quite conceivable, for example, that large hospitals with relatively abundant facilities are simply better organized to report to the carrier those incidents with potential claim-filing consequences.

Outcomes of Claim Action against Insureds

The results of specific claim action against particular insureds will be summarized in the section to follow, in contrast to the depiction of incident outcomes. That is, the insured is now the base of reference rather than the incident as a whole.

Outcome criteria are the claim disposition and amount of payment with respect to particular insureds, classified as to type and medical specialty.

Disposition of claim by type of insured. The relative percent of claim actions falling into the various categories of disposition, with or without payment, were tabulated separately for all insured, and for physicians, dentists, and hospitals (Table 5). It is interesting to note that the distribution of outcomes for all insureds (.42) is roughly the same as that for incidents (.40). This resemblance is not one of mathematical necessity. The bridge between incident outcomes and insured outcomes is by no means a simple one. It is also notable that the range of dispositions when physician insureds are the targets of claim action is quite similar to the all insureds (and the incident) distribution. Since the bulk of medical malpractice claim action involves physicians, this similarity is not unexpected.

Dentists named in claim action show a distinctly different pattern of claim disposition. A very high ratio

TABLE 5

PERCENT OF OUTCOMES IN THE VARIOUS DISPOSITION CATEGORIES FOR SEVERAL TYPES OF INSUREDS

	Pre-Claim	Claim, Pre-Suit	Suit, Before-Trial	Suit, During-Trial	Suit, After-Trial	Totals
1. ALL INSUREDS						
Payment	8.8	7.4	22.1	2.6	1.3	42.2
No Payment	22.5	15.6	13.4	1.3	5.0	57.8
Totals	31.3	23.0	35.5	3.9	6.3	100.0
Ratio of Payment	.28	.32	.62	.67	.21	.42
2. PHYSICIANS						
Payment	5.4	6.9	28.3	3.9	1.7	46.2
No Payment	13.0	15.4	16.5	1.8	7.1	53.8
Totals	18.4	22.3	44.8	5.7	8.8	100.0
Ratio of Payment	.29	.31	.63	.68	.19	.46
3. DENTISTS						
Payment	15.0	22.5	14.4	1.3	0.6	53.8
No Payment	3.7	26.3	10.6	0.0	5.6	46.2
Totals	18.7	48.8	25.0	1.3	6.2	100.0
Ratio of Payment	.80	.46	.58	1.00	.10	.54
4. HOSPITALS						
Payment	11.1	4.8	14.9	1.3	1.1	33.2
No Payment	39.7	13.1	10.5	0.9	2.6	66.8
Totals	50.8	17.9	25.4	2.2	3.7	100.0
Ratio of Payment	.22	.27	.59	.59	.30	.33

(.80) of payment is associated with claim-files closed at the pre-claim stage, and a high proportion of cases (67%) are resolved prior to the suit stage. Thus, alleged misadventures involving dentists tend to be resolved early in the sequence of claim processing, often with some payment to the injured party.

Hospital claim actions also form a distinctive disposition pattern. More than half of such claims were terminated at the pre-claim stage, and a high percentage (69%) were resolved prior to the suit stage. Unlike the case of dentists, however, the pre-suit claims against hospitals were often terminated without payment. Approximately 40% of all claim files involving hospitals were in the category "no claim made by claimant," and may, therefore, indicate an abundance of "warning files" instigated by the hospital in question.

Settlement cost and other outcomes by type of insured (Table 6). The contribution of the several types of insureds to the population of insureds named is detailed in the first column of the table. Within these subpopulations, separately, the values of pertinent outcome indices were derived.

The percent of claims of the "no claim made by claimant" variety, as mentioned, was high for hospitals and for other institutions. The percent was low for physicians (13%) and very low for dentists (4%). Overall percent of claims involving no payment (which includes "no claim made by claimant") showed similar differences. Both hospitals and other institutions had relatively high percents of no payment, whereas physicians and dentists ranked somewhat lower in likelihood of no payment.

Median settlement payments made to claimant on behalf of the insured were roughly estimated for the same types of insureds. The median payment on behalf of physicians was the highest ($4,190). Hospitals and other institutions had median amounts considerably below this amount ($1,700 and $1,400, respectively). An even lower typical settlement ($855) was made in the case of dentists involved in claims.

Settlement cost and other outcomes by medical specialty. The same outcome indices were derived for the medical specialties within the physician category. Tabulations were limited to those specialties representing at least 2% of the physicians named in claim action (Table 7).

The major differences between specialties on these indices are probably reliable, although the smaller ones may be a product of small sample fluctuations. Examination of the table indicates that there is no simple correspondence between ratio of payment and median amount (if any), for example, as measures of malpractice outcome by specialty.

Low scores in both respects characterized the pediatricians, opthalmologists, and psychiatrists. Each of these specialties had a relatively low likelihood of claim action leading to some payment, and a relatively low median settlement amount when payment occurred. Pediatricians, as discussed above, were also under-represented in the claim universe both with respect to their number and patient contact. Psychiatrists were targeted less frequently than their census standing, but at about the same rate as their patient contact.

TABLE 6

OUTCOMES OF CLAIM ACTION AGAINST INSUREDS CLASSED BY TYPE OF INSURED

Type of Files Insured	Percent of Insureds Named in Claim	Percent of Claim-Files, No Claim Made by Claimant	Percent of Claim - Files No Payment	Percent of Claim - Files With Payment	Median Payment* (if any)
Hospitals	36.2	39.7	66.8	33.2	$1,710
Other Institutions	2.7	33.9	60.3	39.7	$1,400
Physicians	49.4	13.0	53.8	46.2	$4,190
Dentists	6.9	3.7	46.2	53.8	$ 855
Other Practitioners	2.5				
Nurses	0.7				
Pharmacists	0.6				
Others	1.0				
All Insured	100.0	22.5	57.8	42.2	$2,480

*Median values were estimated by linear extrapolation within class intervals, a procedure yielding slight overestimation for the types of distribution encountered here.

TABLE 7

OUTCOMES OF CLAIM ACTION AGAINST INSURED DEFENDANTS CLASSED BY MEDICAL SPECIALTY

Specialty	Percent of Physician Insureds Named	Percent of Claim-Files, No Claim Made by Claimant	Percent of Claim-Files No Payment	Percent of Claim-Files, With Payment	Median Payment* (if any)
General Practice	25.0	10.2	50.5	49.5	$4,240
Medical Specialties	11.7	13.6	60.0	40.0	$4,560
Internal Medicine	6.9	10.3	58.6	41.4	$8,350
Pediatrics	2.3	17.3	65.6	34.5	$3,000
Others	2.5	19.4	58.1	41.9	$3,000
Surgical Specialties	42.3	9.8	54.0	46.0	$4,920
General Surgery	14.8	13.9	51.9	48.1	$4,440
Obstetrics/Gyn.	8.3	11.5	52.9	47.1	$6,500
Opthalmology	2.1	11.1	74.1	25.9	$3,000
Orthopedic Surg.	8.8	2.7	50.5	49.5	$8,350
Urology	2.8	11.4	62.9	37.1	$7,500
Others	5.5	2.9	69.6	30.4	$4,200
Other Specialties	21.0	17.4	56.6	43.4	$3,120
Anesthesiology	7.9	22.2	53.4	46.5	$1,920
Psychiatry	2.3	10.3	72.4	27.6	$2,333
Radiology	4.8	16.4	63.9	36.1	$4,160
Others	6.0	14.5	48.7	51.3	$3,600
All Physicians	100.0	13.0	53.8	46.2	$4,190

*Median values were estimated by linear extrapolation with class intervals, a procedure yielding slight overestimation for the types of distribution encountered here.

The specialties with relatively high percents of claims with payment were surgeons, obstetricians/gynecologists, orthopedic surgeons and anesthesiologists. Each of these groups was also over-represented numerically in the claims universe, but the typical settlement costs varied widely. Orthopedic surgery and obstetrics/gynecology specialists were associated with rather high settlements ($8,350; $6,500), when payments were made.

At the other extreme, the typical settlement cost of claims against anesthesiologists was remarkably low ($1,920). Inspection of the payment distribution in this case revealed a considerable spread. Substantial and very high payments were made on behalf of anesthesiologists, although a far greater number of cases involved relatively low amounts.

Another unusual pattern occurred for Internal Medicine specialists. Although clearly under-represented in the claim action universe in terms of census and patient contact baselines, the cost of settlement, when it occurred, was high ($8,350). Thus, a variety of patterns was seen for the Physician Specialty groups with respect to the likelihood of claim action, claim payment, and payment amount.

V. Discussion

The foregoing section presented the findings of the survey as they emerged from objective data analysis. In the current section, some of the highlights of those results are discussed in order to assist the reader in interpreting their significance within some broader framework.

First, with regard to the overall size of the claims universe, the study indicates that 12,000 claims alleging iatrogenic injuries were closed in 1970. Forty percent (4,800 incidents) led to warning files rather than to claims asserted by plaintiffs. The significance of the remaining number (7,200 incidents) can be better appreciated when compared with the total estimated injury rate suggested by other Commission studies.

It appears then, that the consumer rarely converts his grievances (or at least rarely succeeds in converting his grievances) against the health care provider into formal claims. More than 60% of the claims are directed against a single target. Only 20% are directed against three or more targets. Thus, the multiple-defendant case, while not unknown, is not typical. Only 1 in 7 cases involves a derivative claim (e.g., suit brought by spouse for loss of consortium).

Characteristics of Incidents. The incidents leading to malpractice claim action have a wide range of characteristics. But if we had to profile the typical incident we would say that it is most likely one which involves primarily errors of treatment rather than diagnosis, occurs predominantly in hospital settings under non-emergency conditions, and results in non-permanent injury.

The fact that the majority of incidents result in non-permanent injury should not mask the fact that a substantial number of cases (1 in 5) involves fatality, or that even non-permanent injuries can have severe consequences for recovery and personal discomfort.

It is noteworthy that malpractice is not particularly a phenomenon of the emergency ward. Emergency conditions account for only 1 in 5 of the claims-related incidents.

Characteristics of Patients. One of the goals of the survey was to uncover characteristics of patients, if any, which might account for significant portions of the malpractice problem. We did not find evidence that such characteristics exist. Specifically, age, sex, and race contributed to malpractice in about the proportions which would be expected on the basis of physician visits and hospital discharge data. There was some evidence that low income patients were somewhat overrepresented vis-a-vis physician visits, but this was not true with respect to the hospitalization baseline data.

Several other characteristics such as occupational status, marital status, number of dependents, and source of patients' health care costs could not really be evaluated since appropriate normalizing data (i.e., health care utilization figures) were not available.

Thus, as far as we can tell from available information, there is nothing in the patients' demographic make-up which accounts for prevalence of malpractice claims.

Outcomes of Alleged Malpractice Incidents. Much publicity, understandably, has been given to the malpractice suit resulting in large payments to the claimant. Such cases, however, are shown by the results of the survey to be atypical. Significantly, the majority of cases involve no payment to the claimant and where payment is made, its median amount is $2,000. Moreover, the malpractice case is not typically disposed of through suit action. The majority of cases were not found to reach the suit stage, and few (less than 10%) ever go to trial.

Caution should be exercised in interpreting these summary data. , While they can reveal something about the legal/economic consequences of alleged iatrogenic injury, they can tell us nothing about the seriousness of malpractice per se. We cannot say that true malpractice occurs in a minority of cases simply because payment occurs in only a minority of cases. There are many reasons for nonpayment which have little or nothing to do with the merits of a claim or potential claim. These data do not provide any basis for judging malpractice per se.

Involvement of insureds by category. The summary figures described above provide a capsule view of the malpractice problem. But they should not obscure the wide variability which characterizes the involvement of different categories and sub-categories of named insureds. For example, across the broader categories of insureds, median payment amounts range from a low of $885 for dentists to a high of $4,190 for physicians.

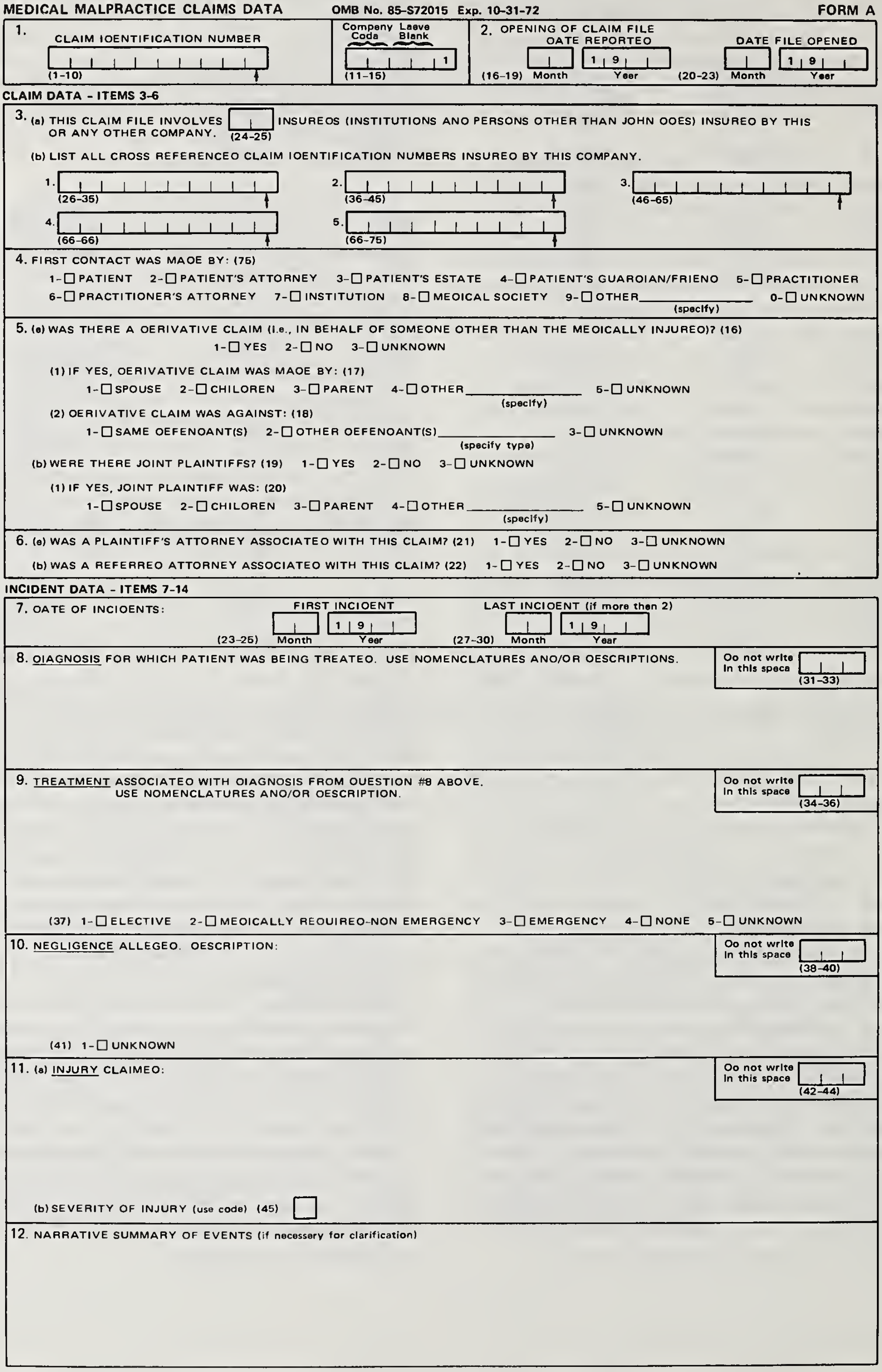
Among physicians, median payment amounts as well as proportionate representation in the closed claim files, varied considerably. Particularly vulnerable were orthopedic surgeons, urologists, obstetricians/gynecologists, and general surgeons in descending order. There were overrepresented in the closed claim files, and were associated with above-average payment amounts.

At the low end of involvement were pediatricians, opthalmologists and psychiatrists. In addition there were several anomalies.. Internists were clearly underrepresented, yet tied with orthopedic surgeons for highest median payment amounts, i.e., their "mistakes" were infrequent but consequential. Anesthesiologists on the other hand were clearly over-represented, but exhibited the lowest median payment amounts. At first glance this result appears inconsistent with the rather well known risk factor inherent in the use of general anesthetics. But the anesthesiologist is very likely to be named co-defendant with the principal surgeon and thus to share the cost. Furthermore, large payment amounts against the anesthesiologist tend to be offset by the frequent occurrence of minor mishaps (e.g., teeth damaged in connection with use of the oxygen mask).

Wide variability is also found in the distribution of case disposition. Hospitals, for example, contribute most heavily to the warning file category. About 50% of the named hospital insureds were found essentially in the preclaim files. In contrast, about 20% of the named practitioner insureds were found in these files.

At the other end of the scale, physicians are represented proportionately more often than either the hospitals or the dentists, i.e., about 15% of the named physician insureds are involved in court litigation, while about 7.0% of dentists and hospitals are so involved.

VI. The Survey Instrument



MEDICAL MALPRACTICE CLAIMS DATA OMB No. 85-S72015 Exp. 10-31-72 **FORM A**

1. CLAIM IDENTIFICATION NUMBER (1-10)

Company Code / Leave Blank 1 (11-15)

2. OPENING OF CLAIM FILE
DATE REPORTED (16-19) Month Year 1 9
DATE FILE OPENED (20-23) Month Year 1 9

CLAIM DATA - ITEMS 3-6

3. (a) THIS CLAIM FILE INVOLVES ☐ (24-25) INSUREDS (INSTITUTIONS AND PERSONS OTHER THAN JOHN DOES) INSURED BY THIS OR ANY OTHER COMPANY.

(b) LIST ALL CROSS REFERENCED CLAIM IDENTIFICATION NUMBERS INSURED BY THIS COMPANY.

1. (26-35) 2. (36-45) 3. (46-65)
4. (66-66) 5. (66-75)

4. FIRST CONTACT WAS MADE BY: (75)
1-☐ PATIENT 2-☐ PATIENT'S ATTORNEY 3-☐ PATIENT'S ESTATE 4-☐ PATIENT'S GUARDIAN/FRIEND 5-☐ PRACTITIONER
6-☐ PRACTITIONER'S ATTORNEY 7-☐ INSTITUTION 8-☐ MEDICAL SOCIETY 9-☐ OTHER ____________ (specify) 0-☐ UNKNOWN

5. (a) WAS THERE A DERIVATIVE CLAIM (i.e., IN BEHALF OF SOMEONE OTHER THAN THE MEDICALLY INJURED)? (16)
1-☐ YES 2-☐ NO 3-☐ UNKNOWN

(1) IF YES, DERIVATIVE CLAIM WAS MADE BY: (17)
1-☐ SPOUSE 2-☐ CHILDREN 3-☐ PARENT 4-☐ OTHER ____________ (specify) 5-☐ UNKNOWN

(2) DERIVATIVE CLAIM WAS AGAINST: (18)
1-☐ SAME DEFENDANT(S) 2-☐ OTHER DEFENDANT(S) ____________ (specify type) 3-☐ UNKNOWN

(b) WERE THERE JOINT PLAINTIFFS? (19) 1-☐ YES 2-☐ NO 3-☐ UNKNOWN

(1) IF YES, JOINT PLAINTIFF WAS: (20)
1-☐ SPOUSE 2-☐ CHILDREN 3-☐ PARENT 4-☐ OTHER ____________ (specify) 5-☐ UNKNOWN

6. (a) WAS A PLAINTIFF'S ATTORNEY ASSOCIATED WITH THIS CLAIM? (21) 1-☐ YES 2-☐ NO 3-☐ UNKNOWN

(b) WAS A REFERRED ATTORNEY ASSOCIATED WITH THIS CLAIM? (22) 1-☐ YES 2-☐ NO 3-☐ UNKNOWN

INCIDENT DATA - ITEMS 7-14

7. DATE OF INCIDENTS:
FIRST INCIDENT (23-26) Month Year 1 9
LAST INCIDENT (if more than 2) (27-30) Month Year 1 9

8. DIAGNOSIS FOR WHICH PATIENT WAS BEING TREATED. USE NOMENCLATURES AND/OR DESCRIPTIONS.
Do not write in this space (31-33)

9. TREATMENT ASSOCIATED WITH DIAGNOSIS FROM QUESTION #8 ABOVE. USE NOMENCLATURES AND/OR DESCRIPTION.
Do not write in this space (34-36)

(37) 1-☐ ELECTIVE 2-☐ MEDICALLY REQUIRED-NON EMERGENCY 3-☐ EMERGENCY 4-☐ NONE 5-☐ UNKNOWN

10. NEGLIGENCE ALLEGED. DESCRIPTION:
Do not write in this space (38-40)

(41) 1-☐ UNKNOWN

11. (a) INJURY CLAIMED:
Do not write in this space (42-44)

(b) SEVERITY OF INJURY (use code) (45) ☐

12. NARRATIVE SUMMARY OF EVENTS (if necessary for clarification)

MEDICAL MALPRACTICE INSURED DATA **FORM B**

1. (a) CLAIM IDENTIFICATION NUMBER ☐☐☐☐☐☐☐☐☐☐ (1-10) (from Block 1, Form A)

Company Code / Leave Blank ☐☐☐☐ 4 ☐ (11-16)

2. THIS FORM IS FOR INSURED NUMBER ☐☐ (17-18) OF ☐☐ (19-20) INSUREDS.

(b) CLAIM IDENTIFICATION NUMBER (if different than Block 1, Form A) ☐☐☐☐☐☐☐☐☐☐ (21-30)

INSURED DESCRIPTIVE DATA - ITEMS 3-18

3. LIMITS OF LIABILITY:

(31) (a) PRIMARY 1-☐ under 100,000 2-☐ 100,000/300,000 3-☐ 200,000/600,000 4-☐ 500,000/1,000,000

5-☐ 1,000,000/1,000,000 6-☐ 1,000,000/3,000,000 7-☐ greater than 1,000,000/3,000,000 8-☐ OTHER ____________ (specify amounts) 9-☐ UNKNOWN

(b) EXCESS OR UMBRELLA LIMIT ☐☐☐☐☐☐☐☐ (32-39) 1-☐ UNKNOWN (40)

4. (a) NUMBER OF KNOWN PRIOR SUITS OR CLAIMS AGAINST THIS INSURED FOR ALLEGED MALPRACTICE.

☐☐☐ (41-43) 1-☐ UNKNOWN (44)

(b) RESULTS OF PRIOR SUITS OR CLAIMS AGAINST THIS INSURED.

☐☐ (45-46) SETTLED WITH INDEMNITY ☐☐ (47-48) LITIGATED WITH INDEMNITY ☐☐ (49-50) PENDING

☐☐ (51-52) SETTLED WITHOUT INDEMNITY ☐☐ (53-54) LITIGATED WITHOUT INDEMNITY ☐☐ (55-56) UNKNOWN

5. TYPE OF INSURED: (57)

1-☐ PRACTITIONER ____________ (specify type)

2-☐ NURSE, R.N.

3-☐ NURSE, L.P.N.

4-☐ PHARMACIST

5-☐ HOSPITAL (if so, skip to Item 18)

6-☐ OTHER INSTITUTION ____________ (specify type) (if so, skip to Item 19)

7-☐ TECHNICIAN ____________ (specify type)

8-☐ OTHER ____________ (specify type)

6. PREMIUM CLASSIFICATION OF RISK (M.D. only): (58) ☐

7. SPECIALTY CODE FROM LIST IN INSTRUCTIONS (M.D., D.O., D.D.S. only): ☐☐ (59-60)

8. BOARD CERTIFICATION: (61) 1-☐ YES 2-☐ NO 3-☐ ELIGIBLE 4-☐ UNKNOWN

9. RACE: (62) 1-☐ BLACK 2-☐ AMERICAN INDIAN 3-☐ CHICANO 4-☐ ORIENTAL 5-☐ CAUCASIAN 6-☐ OTHER 7-☐ UNKNOWN

10. SEX: (63) 1-☐ MALE 2-☐ FEMALE

11. COUNTRY OF BIRTH ____________ 1-☐ UNKNOWN (64)

Leave Blank ☐☐☐☐☐ (65-69)

12. YEAR OF BIRTH ☐☐☐☐ (70-73)

OR AGE AT TIME OF INCIDENT ☐☐ (74-75) 1-☐ UNKNOWN (76)

13. YEAR FIRST MEDICAL DEGREE CONFERRED 1 9 ☐☐ (77-78) 1-☐ UNKNOWN (79)

14. COUNTRY IN WHICH PRIMARY MEDICAL EDUCATION RECEIVED ____________ 1-☐ UNKNOWN (21)

Leave Blank ☐☐☐☐☐ (22-26)

15. TYPE OF PRACTICE: (27)

1-☐ INDIVIDUAL 2-☐ INSTITUTIONAL 3-☐ GROUP PRACTICE 4-☐ UNKNOWN

5-☐ PARTNERSHIP 6-☐ INDUSTRIAL PRACTICE 7-☐ MEDICAL CORPORATION 8-☐ OTHER ____________ (specify type)

16. DATE THIS INSURED FIRST TREATED THE PATIENT ☐☐ Month 1 9 ☐☐ Year (28-31) 1-☐ UNKNOWN (32)

17. DID THIS INSURED CONTINUE TO TREAT THE PATIENT AFTER THE PATIENT RECOGNIZED THE INJURY? (33)

1-☐ YES 2-☐ NO 3-☐ UNKNOWN

18. INFORMATION ON HOSPITAL FROM JAHA HOSPITAL GUIDE ISSUE

CLASSIFICATION CODES			INPATIENT DATA			
CONTROL	SERVICE	STAY	BEDS	ADMISSIONS	CENSUS	OCCUPANCY(%)
(34)(35)	(36)(37)	(38)	(39)(40)(41)(42)	(43)(44)(45)(46)(47)	(48)(49)(50)(51)	(52)(53)(54)

NEWBORN DATA		EXPENSE (THOUSANDS OF DOLLARS)		PERSONNEL
PASSINETS	BIRTHS	TOTAL	PAYROLL	
(55)(56)(57)	(58)(59)(60)(61)	(62)(63)(64)(65)(66)	(67)(68)(69)(70)(71)	(72)(73)(74)(75)

APPROVALS	1	2	3	4	5	6	7	8	9	10	11	12	13
	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)	(33)

FACILITIES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
	(34)	(35)	(36)	(37)	(38)	(39)	(40)	(41)	(42)	(43)	(44)	(45)	(46)	(47)	(48)	(49)	(50)	(51)	(52)	(53)	(54)	(55)	(56)	(57)	(58)

DISPOSITION AND COSTS - ITEMS 19–21

19. DISPOSITION OF THIS CLAIM AGAINST THIS INSURED: (59–60)

WITH NO PAYMENT TO CLAIMANT

11–☐ NO CLAIM MADE BY CLAIMANT
12–☐ CLAIM ABANDONED
13–☐ NO SUIT FILED, STATUTE OF LIMITATIONS
14–☐ SUIT DISMISSED VOLUNTARILY BEFORE TRIAL
15–☐ SUIT TERMINATED BEFORE TRIAL
16–☐ SUIT DISMISSED VOLUNTARILY DURING TRIAL
17–☐ SUIT TERMINATED DURING TRIAL
18–☐ VERDICT IN FAVOR OF DEFENDANT

WITH PAYMENT TO CLAIMANT

21–☐ CLAIM SETTLED AT COMPANY'S INITIATIVE
22–☐ CLAIM SETTLED BEFORE SUIT
23–☐ SUIT SETTLED BEFORE TRIAL
24–☐ SUIT SETTLED DURING TRIAL
25–☐ SUIT SETTLED AFTER TRIAL
26–☐ VERDICT IN FAVOR OF PLAINTIFF

EFFECTIVE DATE OF DISPOSITION INDICATED Month (61–62) Year 1 9 (63–64)

20. WAS THE CASE APPEALED? (65) 1–☐ YES 2–☐ NO 3–☐ UNKNOWN

DISPOSITION OF APPEAL: (66–67)

APPEAL BY PLAINTIFF

31–☐ SETTLED DURING APPEAL
32–☐ AFFIRMED
33–☐ REVERSED
34–☐ REMANDED

(result of remanding)

APPEAL BY DEFENDANT

41–☐ SETTLED DURING APPEAL
42–☐ AFFIRMED
43–☐ REVERSED
44–☐ REMANDED

(result of ramanding)

DATE OF APPEAL Month (68–69) Yaer 1 9 (70–71)

EFFECTIVE DATE OF LAST ACTION INDICATED Month (72–73) Year 1 9 (74–75)

21. COST OF PROCESSING THIS CLAIM:

	Total This Company This Claim		Total This Company This Insured	
(a) LEGAL FEES (21) 1–☐ STAFF 2–☐ RETAINED/CONSULTED 3–☐ UNKNOWN	$ (22–26)	1–☐ UNK (27)	$ (28–32)	1–☐ UNK (33)
(b) OTHER ALLOCATED COSTS	$ (34–38)	1–☐ UNK (39)	$ (40–44)	1–☐ UNK (45)

(c) TOTAL AMOUNT PAID TO PLAINTIFF/CLAIMANT FROM ALL SOURCES	$ (46–52)	1–☐ UNK (53)
(d) AMOUNT PAID TO PLAINTIFF/CLAIMANT ON THIS CLAIM BY THIS COMPANY DATE Month (54–55) Year 1 9 (56–57)	$ (58–64)	1–☐ UNK (65)
(e) AMOUNT PAID TO PLAINTIFF/CLAIMANT ON THIS CLAIM BY THIS COMPANY ON BEHALF OF THIS INSURED	$ (66–72)	1–☐ UNK (73)
(f) AMOUNT PAID BY INSURED	$ (21–27)	1–☐ UNK (28)
(g) AMOUNT PAID BY CO-INSURER INDICATE: (29) 1–☐ EXCESS 2–☐ FACULTATIVE 3–☐ CO-PRIMARY	$ (30–36)	1–☐ UNK (37)
AMOUNT PAID ON BEHALF OF:		
(h) PHARMACEUTICAL COMPANY	$ (38–44)	1–☐ UNK (45)
(i) BLOOD BANKS	$ (46–52)	1–☐ UNK (53)
(j) OTHER MEDICAL SUPPLIERS	$ (54–60)	1–☐ UNK (61)
(k) ARE ANY OF THE AMOUNTS IN ITEMS (h), (i), OR (j) ABOVE INCLUDED IN ITEMS (d) OR (a) ABOVE? (62) 1–☐ YES 2–☐ NO 3–☐ UNKNOWN		
(l) IF YES, INDICATE ITEM AND AMOUNT (63) 1–☐ (d) 2–☐ (e) 3–☐ UNKNOWN	$ (64–70)	1–☐ UNK (71)

INCIDENT DATA (continued)

13. LOCATION WHERE INCIDENT OCCURRED ______ City ______ County ______ State

Leave Blank ☐☐☐☐☐☐☐☐☐ (46-54)

14. FACILITY WHERE INCIDENT OCCURRED: (55)

1-☐ HOME OF CLAIMANT
2-☐ PRACTITIONER'S OFFICE
3-☐ OTHER ______ (specify type)
4-☐ HOSPITAL
☐☐ (56-57) See Code for Specific Location
5-☐ NURSING HOME OR EXTENDED CARE FACILITY
6-☐ NON DOMICILIARY OUTPATIENT FACILITY
7-☐ UNKNOWN

PATIENT DATA - ITEMS 15-24

15. YEAR OF BIRTH ☐☐☐☐ (58-61) OR AGE AT TIME OF INCIDENT ☐☐ (62-63) 1-☐ UNKNOWN (64)

16. MARITAL STATUS: (65) 1-☐ SINGLE 2-☐ MARRIED 3-☐ DIVORCED 4-☐ SEPARATED 5-☐ WIDOWED 6-☐ UNKNOWN

17. RACE: (66) 1-☐ BLACK 2-☐ AMERICAN INDIAN 3-☐ CHICANO 4-☐ ORIENTAL 5-☐ CAUCASIAN 6-☐ OTHER 7-☐ UNKNOWN

18. SEX: (67) 1-☐ MALE 2-☐ FEMALE

19. HEAD OF HOUSEHOLD: (68) 1-☐ YES 2-☐ NO 3-☐ UNKNOWN

20. NUMBER OF DEPENDENTS (see instructions for explanation) ☐☐ (69-70) 1-☐ UNKNOWN (71)

21. PATIENT'S ANNUAL INCOME AT TIME OF INJURY: (72)

1-☐ NONE 2-☐ UNDER $5,000 3-☐ $5,000 to $6,999 4-☐ $7,000 to $9,999 5-☐ $10,000 to $14,999 6-☐ $15,000 and over 7-☐ UNKNOWN

22. OCCUPATION STATUS: (73)

1-☐ EMPLOYED 2-☐ HOUSEWIFE 3-☐ SELF-EMPLOYED 4-☐ UNEMPLOYED 5-☐ RETIRED 6-☐ DEPENDENT CHILD/NON WAGE EARNER 7-☐ UNKNOWN

23. PLACE OF RESIDENCE AT TIME OF INCIDENT ______ City ______ County ______ State

Leave Blank ☐☐☐☐☐☐☐☐☐ (16-24)

24. PATIENT'S HEALTH CARE COSTS WERE COVERED BY: (25) 1-☐ SELF 2-☐ HEALTH INSURANCE 3-☐ MEDICARE

4-☐ MEDICAID 5-☐ WORKMEN'S COMPENSATION 6-☐ OTHER ______ (specify type) 7-☐ UNKNOWN

CASE REVIEW - ITEMS 25-28

25. (a) IN THE COMPANY'S JUDGMENT, DID ANOTHER PERSON(S) NOT NAMED IN THIS OR ANOTHER CLAIM/SUIT CONTRIBUTE TO OR CAUSE THE INJURY? (26) 1-☐ YES 2-☐ NO 3-☐ UNKNOWN

(b) IF YES, INDICATE TYPE OF PERSON: (27)

1-☐ PRACTITIONER ______ (specify type)
2-☐ PATIENT
3-☐ PHARMACIST
4-☐ NURSE, R.N.
5-☐ NURSE, L.P.N.
6-☐ TECHNICIAN ______ (specify type)
7-☐ HOSPITAL
8-☐ OTHER INSTITUTION
9-☐ OTHER ______ (specify type)

26. (a) DID THE COMPANY OBTAIN A MEDICAL EVALUATION OF THE CASE? (28) 1-☐ YES 2-☐ NO 3-☐ UNKNOWN

(b) IF YES, INDICATE MEDICAL EVALUATION BELOW:

		Definitely Yes	Probably Yes	Probably No	Definitely No	Unknown
(29)	(1) THERE WAS MEDICAL INJURY	1-☐	2-☐	3-☐	4-☐	5-☐
(30)	(2) THERE WAS NEGLIGENCE OR BREACH OF PROFESSIONAL DUTY	1-☐	2-☐	3-☐	4-☐	5-☐
(31)	(3) THE MEDICAL INJURY WAS CAUSALLY LINK TO NEGLIGENCE OR BREACH OF DUTY	1-☐	2-☐	3-☐	4-☐	5-☐
(32)	(4) THE INJURY WAS AS SEVERE AS CLAIMED	1-☐	2-☐	3-☐	4-☐	5-☐

27. COMPANY'S INSURANCE EVALUATION OF THE CASE:

		Definitely Yes	Probably Yes	Probably No	Definitely No	Unknown	
(33)	(a) (1) THERE WAS MEDICAL INJURY	1-☐	2-☐	3-☐	4-☐	5-☐	
(34)	(2) THERE WAS NEGLIGENCE OR BREACH OF PROFESSIONAL DUTY	1-☐	2-☐	3-☐	4-☐	5-☐	
(35)	(3) THE MEDICAL INJURY WAS CAUSALLY LINKED TO NEGLIGENCE OR BREACH OF DUTY	1-☐	2-☐	3-☐	4-☐	5-☐	
(36)	(4) THE INJURY WAS AS SEVERE AS CLAIMED	1-☐	2-☐	3-☐	4-☐	5-☐	
(37)	(b) THE CLAIM WAS LEGALLY MERITORIOUS IN TERMS OF LIABILITY	1-☐			4-☐	5-☐	
(38)	(c) SETTLEMENT WAS RECOMMENDED TO THE INSURED	1-☐			4-☐	5-☐	
(39)	(d) INSURED APPROVAL WAS REQUIRED	1-☐			4-☐	5-☐	Not Consulted
(40)	(e) INSURED AGREED TO SETTLE	1-☐			4-☐	5-☐	6-☐

28. DID THIS CLAIM UNDERGO REVIEW BY:

		Yes	No	Unknown	DATE Month	DATE Year		RECOMMENDATION/FINDING For Claimant	RECOMMENDATION/FINDING For Insured
(41)	(a) ARBITRATION	1-☐	2-☐	3-☐	☐☐ (42-43)	1 9 ☐☐ (44-45)	(46)	1-☐	2-☐
(47)	(b) MEDICAL-LEGAL SCREENING PANEL	1-☐	2-☐	3-☐	☐☐ (48-49)	1 9 ☐☐ (50-51)	(52)	1-☐	2-☐
(53)	(c) MEDICAL SOCIETY REVIEW PANEL	1-☐	2-☐	3-☐	☐☐ (54-55)	1 9 ☐☐ (56-57)	(58)	1-☐	2-☐

MALPRACTICE CLAIMS IN THE FEDERAL SECTOR

Rebecca Welch
Beatrix W. Shear

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This paper discusses the medical malpractice claims experience of the Federal health care sector. It is divided into five sections. The first section gives a brief description of the Federal health-care sector, the second describes the process of filing and resolving medical malpractice claims against Federal health-care providers, the third deals with the claims experience of the providers over the last several years, the fourth is an analysis of claims against Federal health-care providers closed during fiscal 1972, and the final section is a summary of the findings and a compilation of recommendations for reducing medical malpractice claims arising out of care provided in Federal health-care facilities.

A Description of the Federal Health Care Sector

The Federal Government provides direct health care to a variety of classes of beneficiaries in the health care facilities of the Army, Navy, Air Force, Public Health Service, and Veterans Administration. In 1970 the Federal Government employed approximately 8 percent of the nation's physicians[1] and accounted for approximately 10 percent of all hospital beds and 5 percent of inpatient admissions, nationwide.[2]

According to a compilation of estimates made by the Army, Navy, Air Force, Public Health Service, and Veterans Administration, approximately 22 million people receive their health care in Federal facilities, representing in all, somewhat over 10 percent of the population of the United States.

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[1] U.S. Bureau of the Census, *Statistical Abstract of the United States: 1972* (93d edition), Washington, D.C., 1972, p. 70.

[2] *Hospitals, Journal of the American Hospital Association, Guide Issue, Part 2*, Vol. 45, No. 15 (Chicago: American Hospital Association, August 1, 1971) p. 460.

This report was originally prepared as a background paper for the Secretary's Commission on Medical Malpractice, U.S. Department of Health, Education & Welfare. Report No. SCMM-RW-FM.

The Army estimates it provides care for over 1.1 million active duty personnel and approximately 3.3 million dependents. The Navy estimates it provides care for over 800,000 active duty personnel and some 2.4 million dependents, and the Air Force estimates it provides care for approximately 750,000 active duty personnel and 2.3 million dependents. In addition, an estimated 800,000 retired military people and some 2 million of their dependents use military health care facilities.

Also an estimated 8 million veterans were cared for in Veterans Administration facilities, including a substantial number of patients receiving nursing-home-type care. The Public Health Service provided care in fiscal 1972 for over 500,000 American Seamen and Coast Guardsmen, members of the National Oceanic Service, and civil servants injured on the job, and for some 2,000 Federal prisoners and close to 500,000 American Indians.

Table 1 shows the number of physicians, inpatient admissions, and outpatient visits for all Federal agencies that provide health care, with the exception of the Public Health Service[3], for the years 1968-1971 and indicates the percent by which the 1971 figures represent increases or decreases over the 1968 figures.

TABLE 1

STAFFING AND USE OF FEDERAL HEALTH CARE FACILITIES
1968 - 1971*

	1968	1969	1970	1971	% Increase or Decrease 1968-1971
NUMBER OF PHYSICIANS**					
Army	6,813	7,032	7,136	6,645	- 2%
Navy	4,868	4,771	4,944	4,647	- 5%
Air Force	4,545	4,255	4,155	4,483	- 1%
Veterans Admin.	7,948	8,086	7,997	8,339	+ 5%
INPATIENT ADMISSIONS					
Army	773,677	737,060	668,916	560,061	-28%
Navy	372,478	380,885	341,716	296,289	-20%
Air Force	379,058	360,905	343,479	335,943	-11%
Veterans Admin.	647,241	667,383	687,037	723,907	+12%
OUTPATIENT VISITS					
Army	28,043,890	28,342,606	27,386,999	25,242,775	-10%
Navy	16,076,904	16,442,749	16,223,567	15,312,111	- 5%
Air Force	18,155,089	17,664,505	17,204,189	16,634,331	- 8%
Veterans Admin.	6,563,787	6,947,074	7,311,894	8,064,982	+23%

*Statistics on the Air Force obtained from the Office of the Judge Advocate General and Surgeon General, United States Air Force. Statistics for the Navy obtained from the Inpatient Statistics Reporting System and NAVMED 1424, Medical Services Report, BUMED Codes 31, 313, 32, and 34. Statistics for the Veterans Administration obtained from *Annual Report of the Veterans Administration, 1967-1971.* Statistics for the Army obtained from the Office of the Surgeon General, United States Army.

**Information on the number of physicians obtained from *Distribution of Physicians in the United States* (Chicago: American Medical Association, 1968, 1969, 1970, 1971)

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[3] The Public Health Service did not supply information for Table 1.

The table shows that staffing and use of military health care facilities in 1971 were less than they were in 1968, while staffing and use of Veterans Administration facilities appear to be on the increase. It also demonstrates that while inpatient admissions at Veterans Administration facilities each year were nearly equal to outpatient visits, the number of outpatient visits at military facilities each year was many times the number of inpatient admissions. These statistics bear out the fact that the military services provide comprehensive health care while the Veterans Administration is oriented toward care for the acutely ill patient in need of hospitalization.

How are Medical Malpractice Claims Against Federal Health Care Providers Filed and Resolved?

Active duty military personnel and civil servants injured at work[4] are precluded from bringing medical malpractice claims or suits, as such, against the Federal Government and, instead, must seek compensation through disability compensation systems provided under other Federal statutes. Other claimants, however, including military dependents and retirees and those non-military and non-civil-service patients served by the Public Health Service, can institute claims and suits under the Federal Tort Claims Act. (28 U.S.C. 1346(b) and 2671 et seq) Veterans who allegedly have suffered medical injuries at Veterans Administration health care facilities have the option of filing tort claims or applying for disability compensation under other statutes.[5]

There are three possible levels of adjudication for malpractice claims against Federal health care providers: *the base command or local operations* level, the *administrative* level, and the *Federal tort suit* level.

Claims for damages under $2,500 can be settled at the *base command* level at military installations or at the *local operations* level in the Veterans Administration and Public Health Service. They generally are resolved under the authority of the claims officer for the facility against which the claim is alleged. Reportedly, however, very few claims are brought at this level. The unpopularity of this settlement mode is somewhat curious in light of the finding that 49.4 percent of non-federal medical malpractice claims that result in plaintiff recovery are resolved for amounts under $2,000.[6] It is an indication that small medical malpractice claims against Federal health care providers are rare, possibly because small claims generated primarily by medical bills do not occur in the Federal sector, since Federal medical care is provided free of charge.

Claims for damages above $2,500 must be filed under the provisions of the Federal Tort Claims Act. Initially, they must be filed as administrative claims.

Responsibility for investigating, evaluating and negotiating settlements for administrative claims is lodged in the Judge Advocate Generals' (JAG) offices for the military services and in the Offices of the General Counsel (OGC) in the Veterans Administration and the Public Health Service. Payments up to $25,000 can be made in settlement of claims at the administrative level. Special exemptions to the $25,000 limits require the approval of the U.S. Attorney General or his designee.

The Air Force JAG office has set up a network of six regional attorneys specially trained as consultant advisors to handle the investigation and evaluation of medical malpractice claims. In addition to their direct activities with respect to claims, the regional attorneys provide a continuing education program on medical law for Air Force health care personnel. They also seek to establish and maintain good working relationships with local Air Force health care personnel.

The facilities and personnel of the Armed Forces Institute of Pathology (AFIP) are also available to the JAG and OGCS offices. During 1972, the Legal Medicine Section of the AFIP reviewed over 200 Federal medical malpractice claims, including a number of potential cases in which no claims had actually been made. The most frequent requests for AFIP claims review come from the JAG offices of the Army and Navy and occasional requests come from the Air Force or the Public Health Service.

If the JAG offices or OGC deny a claim or reach no settlement with the claimant within a six-month period, the claimant may legally bring a *tort suit* against the Government. Often, pre-trial compromise settlements are reached after such suits have been filed, but if a case is not settled, it will eventually come to trial before a judge of the U.S. District Court in the district where the plaintiff resides or where the alleged negligent act occurred. Jury trial is not permitted under the Federal Tort Claims Act. Appeals from the district court are handled through appropriate Federal courts.

Plaintiff attorney fees are controlled under the Federal Tort Claims Act. The contingent fee for legal counsel for an administrative claim is limited to 20%. It is limited to 25% for Federal tort suits. Nationwide, the average contingent fee for a malpractice attorney prosecuting a claim against a non-federal health care provider is approximately one-third of the plaintiff's award[7] The Department of

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[4] Active duty military personnel were ruled ineligible to bring tort action against the U.S. Government in *Feres v. U.S.*, 340 U.S. 135 (1950) and civil servants are precluded under the Federal Employers' Compensation Act.

[5] As of December 31, 1971, 194 veterans or their widows were receiving death or disability benefits for which they had opted rather than filing tort claims.

[6] See "Medical Malpractice Insurance Claims Files Closed in 1970," *Supra*, pp. 1ff.

[7] See "The Medical Malpractice Legal System, Infra, pp. 81ff.

Justice estimates that an attorney incurs approximately $7,500 in expenses in prosecuting a malpractice case against a Federal health care provider to the tort suit level. To make a profit in the average case, the attorney would have to secure an award of over $30,000 for his client.

What is the Magnitude of Malpractice Claims and Payments under the Federal Tort Claims Act?

Table 2, below, shows the number of *administrative claims* filed against the Army, Air Force, Veterans Administration, and Public Health Service in 1968 through 1971. Comparable statistics were not supplied by the Navy because of the inaccessibility of the files and the alleged expense involved in separating out malpractice claims from other claims handled during the four-year period. However, estimates from the Armed Forces Institute of Pathology and the Department of Justice indicate that approximately 50 administrative claims were filed against the Navy in 1971. Since all Federal medical malpractice claims except the few that are settled at the base command level must be filed initially as administrative claims, the figures on Table 2 represent, for practical purposes, annual totals of claims filed against the agencies shown.

The table clearly shows that the number of Administrative medical malpractice claims has increased considerably over the four-year period for each of those agencies reporting, with the four-agency total for 1971 equalling over three and one-half times the total for 1968. This increase appears to be particularly marked in contrast to the decrease in the number of physician, inpatient admissions, and outpatient visits that occurred in Army and Air Force health care facilities during the same period. For the Veterans Administration, the number of physicians and the volume of inpatient admissions and outpatient visits increased by only relatively small amounts, while the number of administrative claims nearly tripled between 1968 and 1971.

The rate of increase in the number of claims filed, however, appears to be tapering off for the Army, Air Force, and Veterans Administration. Air Force and Veterans Administration claims increased by only 14 percent and 26 percent, respectively, between 1970 and 1971, the lowest rates of increase experienced by those agencies during any of the years shown. The number of administrative medical malpractice claims filed against the Army declined by 4 percent between 1970 and 1971. The largest percentage increase in the number of claims filed against the Air Force, Veterans Administration, and Public Health Service took place between 1968 and 1969: 314 percent, 80 percent, and 100 percent respectively.

In contrast to the other three agencies, the Public Health Service, which experienced a slight decline in claims between 1968 and 1969, showed its biggest percentage increase in claims between 1970 and 1971, a 90 percent rise.

Adding to the administrative claims filed against the Navy (estimated to be 50) to the claims filed against the other agencies in 1971, one comes up with an estimated total of 281 medical malpractice claims filed in that year against all Federal health care providers, a small number in contrast to the number of malpractice claims filed against non-federal health care providers, estimated to be 12,600 in 1970.[8]

TABLE 2

ADMINISTRATIVE MEDICAL MALPRACTICE CLAIMS
FILED AGAINST FEDERAL HEALTH CARE PROVIDERS
1968 - 1971

Agency	1968	1969	1970	1971	% Increase 1968-1971
Army (CY)*	19	38	48	46	142%
Air Force	7	29	42	48	586%
Veterans Administration	30	54	94	118	293%
Public Health Service	9	8	10	19	111%
Annual Totals (without Navy)	65	129	194	231	255%

*Statistics for the army were based on the calendar year while statistics for the Air Force, Veterans Administration, and Public Health Service are based on the fiscal year.

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[8] See "Medical Malpractice Insurance Claims Files Closed in 1970," *supra*, pp. 1ff.

The amount of claimant recovery for those claims which were settled at the administrative level in 1968-1971 by the Army, Air Force, and Veterans Administration is shown on Table 3, below.

TABLE 3

PAYMENTS IN SETTLEMENT OF ADMINISTRATIVE CLAIMS AGAINST FEDERAL HEALTH PROVIDERS 1968 -1971

Agency	1968	1969	1970	1971
Army	$151,665	$370,100	$373,000	$175,250
Air Force	1,992	0	140,069	231,000
Veterans Administration	unknown	unknown	unknown	291,900
Total (excluding Navy and Public Helath Service)				$698,150

No apparent trend emerges with regard to the amounts paid out in settlement of administrative claims for the Army and Air Force between 1968 and 1971. The Army paid out about twice as much in settlements in the middle years, 1969 and 1970, as it did in the beginning and end years of the period shown, while the Air Force paid out very little in 1968, nothing at all in 1969, but increasingly substantial sums in 1970 and 1971.

Reportedly, the Navy and the Public Health Service settle very few of their claims at the administrative level. We can therefore assume that the total of Federal payments for administratively-settled medical malpractice claims was something under $1,000,000 in 1971.

Although the available data do not allow us to calculate the mean administrative claims settlement amount for the Navy, Air Force, Veterans Administration, or Public Health Service, we can calculate a mean amount for Army claims settled administratively between 1968 and 1971.

TABLE 4

THE NUMBER AND COST OF ADMINISTRATIVE CLAIMS SETTLED BY THE ARMY IN 1968 - 1971

	No. of Admin. Claims Settled	Total Plaintiff Recovery	Mean Plaintiff Recovery per Claim
1968	7	$ 151,665	$21,666
1969	14	370,100	26,436
1970	15	373,000	24,867
1971	9	175,250	19,472
Totals	45	$1,070,015	$23,241

The data show that the number and average value of medical malpractice claims settled administratively were larger in 1969 and 1970 than in 1968 and 1971. The mean value of administrative claims settled in 1969 slightly exceeded the $25,000 claim limits, presumably due to special exceptions granted to the Army. The lowest annual mean settlement amount was $19,472, in 1971, and the average over the four-year period was $23,778, close to the $25,000 claim limits.

Mean annual settlements may be higher for the Army than for other Federal health care agencies inasmuch as the Army is said to have a more lenient policy with respect to seeking exemptions to the $25,000 administrative settlement limits.

The disposition of medical malpractice *tort suits* closed under the Federal Tort Claims Act from 1968 through 1971 is shown in Table 5.

Since all compromised settlements resulted in some plaintiff recovery, the table demonstrates that plaintiffs recovered damages in approximately 77 percent of the tort suit cases closed over the five-year period shown. It also shows that most of the plaintiff recoveries were accomplished through compromises made before trial rather than through judgments. Plaintiff judgments account for only 15 percent of the suit dispositions, while defense judgments account for 23 percent; thus plaintiffs were successful in only 40 percent of the cases that went to trial.

The mean value of the 212 compromised settlements was $20,942. This was less than half the $44,380 mean value of the 47 plaintiff judgments during the same five-year span. The compromised settlements average less than the $25,000 maximum allowed for claims settled administratively.

Table 5 shows that plaintiffs recovered a total of slightly over $1,000,000 from tort suits closed in 1971. Together with the estimated $1,000,000 plaintiffs recovered in administrative claim settlements in 1971 (see page 00), the approximate cost to the Federal Government is $2,000,000 for medical malpractice claims closed in that year. This total assumes that the amount paid out for claims settled at the base command and local operative level was minimal. The $2,000,000 figure, however, does not include the cost to the government of providing additional medical care to medically injured patients.

Analysis of 141 Administrative Medical Malpractice Claims Closed in Fiscal 1972

In an effort to learn more about the types of medical malpractice claims asserted against federal health-care providers, 141 claims closed in fiscal 1972 were examined to determine the medical problems for which they were seeking care, the alleged negligence, the location where the incident occurred, the severity of injury, the disposition, and for 115 of the claims, the medical evaluation received. All of the administrative claims closed by the Army (22), Air Force (34), and Public Health Service (15) were studied as were 70 of the 120 administrative claims closed by the Veterans Administration. No Navy claims were available for study.

TABLE 5

DISPOSITION OF MEDICAL MALPRACTICE TORT SUITS CLOSED UNDER THE FEDERAL TORT CLAIMS ACT 1968 - 1971

Year	Number of Cases Closed	Cases Compromised Before Trial	Plaintiff Judgments	Defendant Judgments	Plaintiff Recovery in Compromised Cases	Plaintiff Recovery from Judgments	Total Plaintiff Recovery
1967	58	53%	21%	26%	$ 484,900	$640,435	$1,125,335
1968	89	74%	10%	16%	1,541,003	477,277	2,018,280
1969	70	56%	10%	34%	1,286,500	223,462	1,509,962
1970	62	68%	13%	19%	597,875	205,081	802,956
1971	58	59%	19%	22%	528,602	539,610	1,068,212
Average*	67	62%	15%	23%	$ 887,776	$401,163	$1,304,949

*Yearly average for 5-year period

MEDICAL PROBLEMS OF CLAIMANTS

Table 6 shows the distribution of claimants according to medical problems that caused them to seek care at the time the alleged malpractice occurred.

Some one-fourth of the claimants were suffering from musculoskeletal injuries, including such conditions as broken bones or back injuries. About another quarter were suffering from genito-urinary conditions (12.50 percent) or from circulatory ailments (11.72 percent). The medical problems of the remaining half of the claimants were scattered over 14 other possibilities. Fifteen other possible medical problems were listed on Table 6, even though they were specified in no claims.

NEGLIGENCE ALLEGED

Table 7 shows the negligence alleged against Federal health care providers in the 141 claims studies.

Claims arising out of alleged improper treatment were more than three times as many as claims arising out of alleged failure to diagnose. By far, the most common single type of negligence alleged was improper treatment involving a surgical procedure. The second most common types of negligence alleged, accounting for about an eighth of the claims, was improper supervision, cases of falls or suicides which occurred while patients were left unattended. Drug overdoses or side effects were the third most common type, accounting for nearly 10 percent of the claims. Together, these alleged surgical, supervision, and drug errors were responsible for over half the claims studied.

The type of surgery undergone by those 41 claimants whose claims stemmed from negligence associated with surgery are shown in Table 8. Musculoskeletal and Genito-urinary surgery account for over a third of the types, with the rest scattered among the other 12 types listed.

TABLE 6

NUMBER OF CLAIMANTS LISTED BY DIAGNOSED MEDICAL PROBLEMS

Medical Problems	No. of Claimants	% of Total	% of Known
Musculoskeletal/Connective	32	23.70	25.00
Genito-Urinary	16	11.85	12.50
Circulatory	15	11.11	11.72
Digestive	10	7.41	7.81
Nervous/Sense Organs	10	7.41	7.81
Mental	10	7.41	7.81
Respiratory	7	5.19	5.47
Pregnancy/Child Birth	7	5.19	5.47
Endocrine/Nutritional	6	4.44	4.69
Accidents/Poisoning	4	2.96	3.13
Skin/Subcutaneous Tissue	3	2.2	2.34
General Medical Examination	2	1.48	1.56
Blood/Blood Forming Organ	2	1.48	1.56
Neoplasm	1	0.74	0.78
Infective/Parasitic	1	0.74	0.78
Other Exam	1	0.74	0.78
Infective/Parasitic Disease	1	0.74	0.78
Congenital Anomalies	0	0.00	0.00
Perinatal Morbidity/Mortality	0	0.00	0.00
Ill-defined Symptoms	0	0.00	0.00
Psychiatric Exam	0	0.00	0.00
Radiological Exam	0	0.00	0.00
Laboratory Exam	0	0.00	0.00
Pregnancy Exam	0	0.00	0.00
Well Baby/Child Care	0	0.00	0.00
Eye Exam	0	0.00	0.00
False Positive Serology	0	0.00	0.00
Clinical Research	0	0.00	0.00
Carrier Of Infection Organism	0	0.00	0.00
Aftercare	0	0.00	0.00
Surgical Aftercare	0	0.00	0.00
Medical Aftercare	0	0.00	0.00
Other/Unspecified	0	0.00	0.00
Unknown	13		
Total	141	100.00	100.00

TABLE 7

NUMBER OF CLAIMANTS LISTED BY ALLEGED NEGLIGENCE

Improper Treatment	AF	Army	PHS	VA	Total	Percent
Surgical	7	8	3	23	41	29.1
Improper supervision	3	1	2	11	17	12.1
Drug overdoses/Side effect	4	1	1	8	14	9.9
Fracture, Dislocation		2	2	4	8	5.7
Prescriptions, Therapy	1			4	5	3.6
Equipment Failure	3			2	5	3.6
Infection	1	2			3	2.1
Transfusion	1	1		1	3	2.1
Anesthesia		1	1		2	1.4
Injection				2	2	1.4
Abandonment		1		1	2	1.4
Sub Totals	20	17	9	56	102	72.4
Failure to Diagnose						
Mental condition, Misc.	1	3	2	4	10	7.1
Cancer	3	1		2	6	4.3
Fracture	2	1	2		5	3.6
Pregnancy related	2				2	1.4
Ulcers, Gastrointestinal	2				2	1.4
Lacerated tendon, nerve	2				2	1.4
Hemorrhage	1				1	0.7
Appendicitis				1	1	0.7
Due to lack of attention				1	1	0.7
Heart Disorder	1				1	0.7
Sub Totals	14	5	4	8	31	21.3
Claims not based on Negligence	0	0	0	4	4	2.8
Unknown	0	0	2	2	4	2.9
Total*	34	22	15	70	141	99.4

*Total does not add up to 100 percent because percentages were rounded to the nearest tenth of one percent.

TABLE 8
TYPE OF SURGICAL TREATMENT

Treatment	AF	Army	PHS	VA	Total
Genito-urinary			1	8	9
Musculoskeletal		2	3	3	7
Cardiovascular				4	4
Gynecological	2	1			3
Digestive		2		1	3
Endocrine	1	1		1	3
Ear	1			1	2
Maternity	1	1			2
Neurological				2	2
Miscellaneous Diagnosis				2	2
Respiratory				1	1
Catheterization (heart)	1				1
Plastic Surgery	1				1
Pulmonary Diagnosis		1			1
Total	7	8	4	23	41

THE LOCATION WHERE THE INCIDENT OCCURRED

The location within health care facilities where the alleged malpractice occurred are shown in Table 9.

Nearly all the incidents occurred in a hospital setting, with only 12% occurring in an outpatient facility. More than half within the hospital were located in the operating or post-operative recovery rooms.

TABLE 9
LOCATION OF INCIDENTS

Location	Frequency of Occurrence
Operating Room	40.8%
Patient's Room	14.6%
Emergency Room	13.8%
Outpatient Facility	11.5%
Post-operative Recovery	5.4%
Intensive Care	1.5%
Radiation–Diagnosis/Treatment	1.5%
Physical Therapy	0.8%
Labor and Delivery Room	0.8%
Nursery	0.8%
Other and Unknown	8.5%
Total	100.0%

Overall, some 29 percent of the closed claims studied arose from injuries rated insignificant or minor (categories 1, 2, and 3 on the severity scale). While between 30 and 33 percent of the Air Force, Public Health Service and Veterans Administration claims fell into these categories, however, only 14 percent of the Army cases did. Categories 6, 7, and 8 on the severity scale, significant, major, and grave permanent injuries, the kind that often result in very high malpractice awards when they are brought against non-Federal health-care providers[9] occurred in between 13 and 23 percent of the Air Force, Veterans Administration, and Public Health Service cases, but accounted for 33 percent of the Army cases closed in 1972. The Army also had the highest percentage of death cases, although the difference between the Army, Air Force, and Veterans Administration in this regard was a small one. The Public Health Service, on the other hand, had a substantially smaller proportion of death cases and a smaller proportion of significant, major, and grave permanent injury claims than the other agencies.

When the severity rating for the 141 Federal claims closed in 1972 are compared to the severity ratings for non-Federal medical malpractice claims closed in 1970[10], a difference in average severity becomes apparent.

SEVERITY OF ALLEGED INJURY

All 141 claims examined for this study were rated for severity on the severity scale below:

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[9] See "The Medical Malpractice Legal System", *Infra*, pp. 81ff.

[10] "Medical Malpractice Insurance Claims Files," *Supra*, pp. 1ff.

SEVERITY SCALE

Amount of Recovery	Severity of Injury	Delay in Recovery	Examples
1 - No Injury	Insignificant	N/A	Psychological, fright, catheter incorrectly inserted, dissatisfaction (doctor too slow), unauthorized autopsy
2 - Temporary Injury	Minor	No delay	Lacerations, bruises, contusions, minor scars, rash, broken caps on teeth, minor allergic reaction
3 - Temporary Injury	Minor	Delayed	Operation induced infection, misset fracture, failure to diagnose glass in cut, staph infection from lack of antibiotics, broken ankle from fall
4 - Temporary Injury	Major	Delayed	Burns, surgical material left, drug side-effect, severed nerve or tendon
5 - Permanent Injury	Minor	N/A	Loss of fingers or toes, foot drop, withered arm, loss of teeth, dysfunction of ankle
6 - Permanent Injury	Significant	N/A	Deafness, loss of limb, loss of eye, loss of one kidney or lung, gross deformity of limb
7 - Permanent Injury	Major	N/A	Paraplegia, blindness, loss of two limbs, brain damage, etc.
8 - Permanent Injury	Grave	N/A	Quadraplegia, severe brain damage, comatose, lifelong care, etc.
9 - DEATH	N/A	N/A	N/A
0 - Unknown			

The mean severity rating for the non-Federal claim is 4.53 while the mean severity rating for the 141 Federal claims studied is 5.25. Some two-thirds of the private sector claims were generated by temporary injuries, compared to 38 percent of the Federal claims, and the percentage of Federal Claims receiving a 6, 7, or 8 rating on the severity scale is over twice the corresponding private sector percentage.

DISPOSITION

Table 11 shows what administrative action was taken on the 141 Federal claims studied.

The Air Force, Public Health Service, and Veterans Administration disallowed an overwhelming majority of their administrative claims, while the Army allowed payment in some 59 percent of its claims.

The variation in administrative claims-settlement rates may well reflect the varying claims-handling policies of the agencies shown. As noted earlier, the Army reportedly is more active than the other agencies in seeking exemptions to the $25,000 administrative payment limit. The Public Health Service, the agency with the highest disallowance rate, reportedly does not make a strong effort to settle its malpractice claims at the administrative level, preferring to turn the cases over to the Justice Department for resolution at the suit stage.

MEDICAL EVALUATION

One hundred fifteen of the 141 Federal claims studied received, medical evaluations from the various agencies. The results of these evaluations are shown in Table 12.

According to the table, medical injury was present o probable in nearly, three quarters of the claims, but medical negligence was present or probable in only about a third. The figures indicate that in those instances where medical negligence was present, it was causally linked to the injury claimed. The injury was evaluated to be as severe as claimed or probably so in two-thirds of the cases receiving evaluations.

TABLE 10

PERCENTAGE DISTRIBUTION CLAIMS ON THE NINE POINT SEVERITY SCALE

Severity Rating	AF (34 Claims)	Army (22 Claims)	PHS (15 Claims)	VA (70 Claims)	All 141 Claims
Unknown	0%	5%	0%	0%	1%
1	12%	0%	13%	9%	9%
2	18%	9%	7%	11%	12%
3	3%	5%	13%	10%	8%
4	9%	5%	20%	9%	9%
5	18%	18%	20%	16%	17%
6	18%	23%	13%	14%	16%
7	0%	5%	0%	6%	4%
8	0%	5%	0%	3%	2%
9	24%	27%	13%	23%	23%
Total*	102%	102%	99%	101%	101%

*Percentages do not add up to 100 percent in some cases, because they were rounded to the nearest whole percent.

TABLE 11

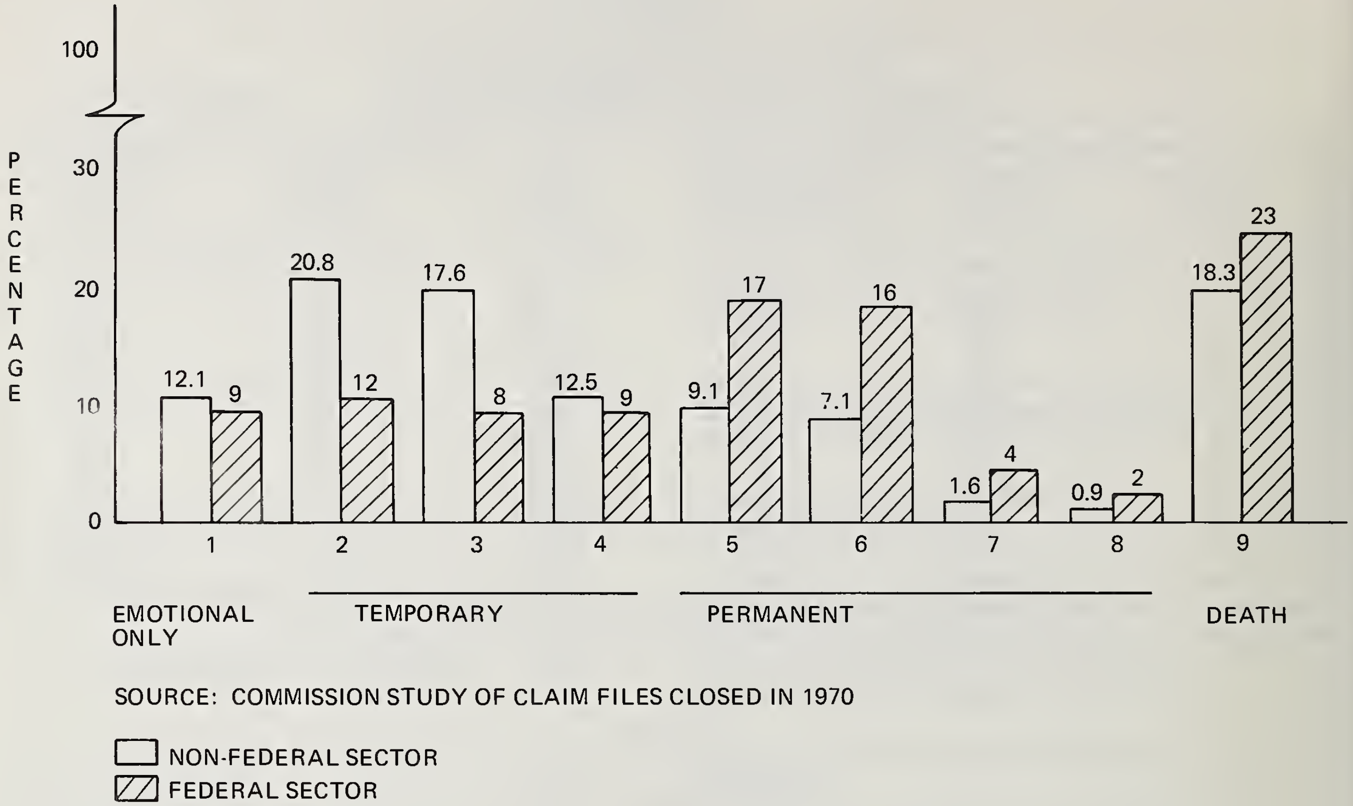
DISPOSITION OF CLAIMS

Agency	No. of Claims	Payment Allowed	Payment Disallowed
Air Force	34	15%	85%
Army	22	59%	41%
Public Health Service	15	7%	93%
Veterans Administration	70	26%	74%
Total	141	26%	74%

Summary and Recommendations for Reducing Federal Medical Malpractice Claims

Important differences separate the Federal from the non-federal health care sector and make comparison of the malpractice claims experience of the two difficult:

1. Certain classes of Federal patients (estimated to be approximately 10 percent of the total) are prohibited from bringing tort claims against Federal health-care providers.
2. Those eligible to bring tort claims against Federal health-care providers include a disproportionate number of women and children (military dependents) and older and/or disadvantaged people without substantial incomes (veterans, Federal prisoners, merchant seamen, American Indians living on reservations). These people are less likely to suffer lost earnings or earning potential as a result of medical injury. In addition, many of them may not be aware of their right to bring claims against the Government or, as military dependents, may feel that bringing such actions would hurt the military careers of their spouses or parents.
3. Medical malpractice claims against Federal health-care providers must be asserted under the rules of the Federal Tort Claims Act, which requires administrative adjudication of claims before any suit can be filed, limits attorneys fees, and prohibits jury trial.
4. Patients in Federal health-care facilities do not bear the cost of their medical treatment or of that resulting from possible malpractice and therefore have little economic incentive to sue for recovery of medical expenses.



SOURCE: COMMISSION STUDY OF CLAIM FILES CLOSED IN 1970

FIGURE 1
SEVERITY OF INJURIES ALLEGED IN MEDICAL MALPRACTICE CLAIM FILES
CLOSED IN 1970 COMPARED WITH 141 FEDERAL CLAIMS CLOSED IN FISCAL 1972

Despite these differences and the incomplete nature of the claims data available from Federal agencies, the frequency of malpractice claims brought against Federal health-care providers appears to be low compared to the frequency with which malpractice claims are filed against non-federal health-care providers. Approximately 12,600 non-federal sector claims[11] and 244 Federal claims (including an estimated 50 Navy claims) were filed in 1970 (see Table 2, page 00). On the assumption that 74 percent[12] of the non-federal claims and 88 percent (see Table 9) of the Federal claims were based on hospital injuries, the ratio for 1970 of 9,324 claims based on hospital injuries to 30,018,000 hospital admissions for the non-federal sector is 31 per 100,000 whereas the ratio of 215 Federal claims based on hospital injuries to 1,567,000 Federal hospital admissions, (not counting active duty military personnel or civil servants injured on the job)[13] is 14 per 100,000. This comparison, of 31 per 100,000 hospital admissions, in the non-federal sector against approximately 14 per 100,000 hospital admissions in the Federal sector, suggests that the Federal sector has less than half the relative number of malpractice claims as the private sector.

Although less frequent than the non-federal sector, claims in the Federal sector tend to be based on more serious injuries and the sums recovered appear to be higher. In 1971, the Federal Government paid out about $2,000,000 in settlements and judgments for medical malpractice claims and suits not counting additional medical expenses generated by the medical injuries suffered.

Most Federal, as well as non-federal[14], claims studied arose out of alleged "improper treatment" rather than "failure to diagnose." Surgical errors were the most common type of negligence alleged in the 141 Federal sector fiscal 1972 claims analyzed for this study. Improper supervision and negligence associated with drug overdoses or side effects were the second and third most common types.

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[11] *Report of the Secretary's Commission on Medical Malpractice*, p. 6.

[12] *Supra*, p. 10.

[13] Hospital admission data is based on figures in *Hospitals, Journal of the American Hospital Association, Guide Issue.* Part 2, p. 460. The figure for Federal hospital admissions was reduced by 10 percent to allow for those hospital patients who are civil servants injured on the job or active duty military personnel who have no legal right to bring tort claims against the Government. No adjustment was made for that portion of potential Veterans Administration Claimants who sought disability compensation under veterans benefits programs rather than filing tort claims.

[14] See "Medical Malpractice Insurance Claims Files", *Supra, p.* pp. 1ff.

TABLE 12

MEDICAL EVALUATION OF 115 ADMINISTRATIVE FEDERAL MEDICAL MALPRACTICE CLAIMS CLOSED IN FISCAL 1972

	Definitely Yes	Probably Yes	Definitely No	Probable No	Total*
There was medical injury	54%	19%	15%	12%	101%
There was medical negligence	22%	16%	23%	40%	101%
Medical injury was causally linked to medical negligence	22%	14%	24%	40%	100%
The injury was as severe as claimed	48%	18%	22%	12%	100%

*Percentages do not add up to 100 percent in some cases because they were rounded to the nearest whole percent.

Although the frequency of Federal medical malpractice claims increased by about 250 percent between 1968 and 1971, the rate of increase appeared to be slowing by 1971, at least for the Army, Air Force, and Veterans Administration.

Among the agencies whose fiscal 1972 claims were studied, the Army appeared to generate the most serious claims and also to be the most active in reaching settlement with claimants at the administrative level. The Public Health Service had the least serious claims and settled the smallest percentage administratively.

RECOMMENDATIONS

The Justice Department, the Armed Forces Institute of Pathology, the Interdepartmental Committee on Medical Malpractice[15] and offices of the JAG and OGC, the Federal agencies that provide direct health care were queried for suggestions on how medical malpractice claims could be reduced within the Federal sector. Their suggestions, some of which are already in effect among some Federal health care providers, are summarized as follows:

1. Physicians should take the time to establish good rapport with their patients, particularly to help them understand the nature of any surgical procedures to be performed and the possible results of these and other procedures.
2. Physicians should be required to attend continuing education courses in their fields. The courses should emphasize new methodology and injury prevention and should be offered at government expense and on government time.
3. Physicians, particularly surgeons, should seek consultation whenever they have the slightest doubt that their diagnosis or proposed treatment of a patient is correct.
4. Since the facilities and medical specialists at various government health-care installations vary greatly, patients should be transferred as promptly as possible to installations where they can receive adequate care if facilities or personnel at the installation where they are first admitted are inadequate for their medical needs.
5. A uniform record-keeping system to record circumstances surrounding such incidents as slips and falls, suicides, and drug-related injuries should be established to provide feedback useful in preventing future injuries of a similar nature.o
6. Hospital injury prevention programs with full-time safety officers who would have the job of making employees aware of hazards and removing unsafe or inadequate equipment should be established throughout the Federal health-care sector.
7. Complete, accurate, legible medical records must be kept on each patient. To facilitate this task, computerized record-keeping systems and dictation and stenographic service might be provided.
8. Informed consent of patients for surgical or other procedures should be noted, specially, on medical records.
9. Federal health-care personnel should be required to attend seminars orienting them to their medical-legal responsibilities and to the practices of their agencies in handling medical malpractice claims.

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[15] The Interdepartmental Committee on Medical Malpractice, composed of representatives of the Army, Navy, Air Force, Veterans Administration, Department of Health, Education and Welfare, Department of Justice, and Department of Housing and Urban Development, was set up by H.E.W. Secretary Elliot L. Richardson to collect and exchange information on medical malpractice within the Federal health care sector and to propose methods to minimize the problem.

DEFENSIVE MEDICINE

Eli P. Bernzweig, J.D.

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The purpose of this paper is to outline briefly the pertinent issues associated with the subject of defensive medicine. The intent is not to cover every aspect of the subject in detail, but simply to set forth the highlights.

Defensive Medicine-What Is It?

There is no general agreement as to what is meant by the term "defensive medicine," and this widely-used expression has come to mean different things to different people. Among students of the malpractice phenomenon, it is generally accepted that a sizeable number of physicians have altered their modes of medical practice both to forestall the possibility of lawsuits by their patients and to provide a good legal defense in the event such lawsuits are instituted. Because these altered modes of practice are protective stratagems, they are commonly referred to as forms of "defensive medicine."

A Duke Law Journal study[1] made a distinction between "positive defensive medicine" and "negative defensive medicine"—positive defensive medicine being the overutilization of diagnostic and treatment procedures which are medically unjustified, and negative defensive medicine being those procedures or activities which a physician refuses to undertake or engage in because of the fear of a later malpractice suit. The Duke study, however, made no attempt to measure the latter, but focused solely on positive defensive medicine acts.

In his article on the subject of defensive medicine in the *Milbank Memorial Quarterly*, Nathan Hershey limited the expression to "poor practice," i.e.,"a deviation from what the physician believes is sound practice and is generally so regarded, induced by a threat of liability."[2] Under this definition, any act or omission of an action which is not in the patient's best interests and not deemed sound medical practice, is considered a type of defensive medicine.

While the legal commentators have taken pains to differentiate between varieties of defensive medicine, the general public has come to use the term almost always in a derogatory sense, and this is unfortunate because it tends to blur the distinction between good and bad, desirable and undesirable medical practices. As noted by Hershey, "The problem in studying the phenomenon of defensive medicine

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[1] "The Malpractice Threat: A Study of Defensive Medicine," *Duke Law Journal*, Vol. 5 (Dec. 1971), p. 939 993

[2] Nathan Hershey, "The Defensive Practice of Medicine, Myth or Reality," *Milbank Memorial Quarterly*, Vol. L, No. 1, Part 1 (Jan. 1972), p. 69-97

This report was originally prepared as a background paper for the Secretary's Commission on Medical Malpractice, U.S. Department of Health, Education, and Welfare, Report No. SCMM-EB-DM.

is that not all of the practices motivated for liability considerations result in poor quality care. It is, therefore, difficult to draw the line between where good medicine stops and defensive practice begins."[3]

Is Defensive Medicine Necessarily Poor Medicine?

The perceived threat of possible malpractice litigation undoubtedly motivates some physicians to perform too many tests and procedures on the one hand, and to decline to undertake risky but indicated procedures on the other. It is asserted by many that defensive medicine of the former type (i.e., so-called positive defensive medicine) has led to a substantial increase in the costs of medical care, and possibly to a decrease in the quality of medical care as well.

Examples of this form of defensive medicine which are frequently cited include:

1) excessive utilization of x-ray and routine diagnostic procedures;
2) excessive utilization of laboratory tests;
3) additional office visits to follow up medical conditions which might give rise to complications;
4) excessive utilization of medical consultations;
5) more instances of hospitalization for borderline cases which might be treated as well at home;
6) extended hospitalization of patients following surgery to avoid the possibility of premature discharge and possible complications at home.

Although nearly everyone would agree that the described forms of defensive medicine are being practiced to some extent, there is lack of agreement among physicians that all of these practices represent poor quality medical care. For example, the same practice or procedure which one physician claims he employs solely for medical-legal (i.e., defensive) reasons may be employed by a substantial number of other physicians because they believe it to be the appropriate treatment in the given circumstances, and of genuine medical benefit. By the same token, any particular medical test or procedure may be viewed as being beneficial or non-beneficial by the physician who employs the test or procedure depending solely upon his subjective motivations. This is one of the major reasons why it is difficult (if not impossible) to measure the extent of defensive medicine practices, and why it is sometimes extremely difficult to draw a clear line between where good medical care ends and the purely selfish interests of the physician begin. A physician who states that a particular diagnostic test is not medically necessary may really mean that it is not cost-effective, i.e., not worth the additional expense involved. But this is different than saying that the test or procedure itself is poor medicine in the clinical sense.

There are some who say that the quality of medical care has been improved by the threat of litigation[4]. They point to improvements in the quality of care in a number of important respects. Examples frequently cited include:

1) better emergency room treatment;
2) better cardiac-arrest procedures;
3) reduction in the use of poorly-trained or untrained medical assistants, particularly in anesthetic practice;
4) more judicious use of potentially harmful drugs;
5) better medical record-keeping;
6) more widespread use of consultants in borderline diagnostic situations;
7) better communication with patients and their families regarding proposed surgical procedures.

As noted in a 1970 survey conducted by the American Medical Association,[5] there are other factors beside the threat of a lawsuit which may prompt the ordering of extra tests, including: 1) the demands of patients for optimum care; 2) improvements in diagnostic techniques; and 3) the use of such procedures as teaching tools. As previously noted, what complicates analysis of this subject is the simple fact that the decision as to whether an act or a procedure constitutes defensive medicine is dependent almost exclusively on the subjective judgment of the physician. In short, it must be recognized that there is no single type of defensive medicine nor any single motivational factor for procedures which are allegedly defensive in nature.

How Widespread Are Defensive Medicine Practices?

The extent to which physicians engage in defensive medicine practices has not been accurately determined. For the past several years, a number of formal and informal surveys of physicians have indicated that between 50 and 70 percent of all physicians claim they practice defensive medicine of one sort or another with varying degrees of regularity.

Neither the Duke study nor the Hershey study produced empirical data sufficient to draw any statistically supportable conclusions regarding the extent of defensive medicine practices, but the Duke study concluded that the alleged practices were "not as extensive as previously believed,"[6] and the Hershey study concluded that "the phenomenon of defensive medicine is one that is far too glibly discussed without supporting factual data," and that "the physicians who discuss it and express their belief that it is quite widespread may represent only a small, vocal portion of the medical community."[7]

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[3] *Ibid.*, p. 73.

[4] Mark S. Blumberg, "The Costs to Society of Medical Malpractice," paper presented at The Conference on Medical Malpractice sponsored by The Center for The Study of Democratic Institutions, Santa Barbara, Calif., Sept. 1-3, 1971.

[5] *1970 Professional Liability Survey* (Chicago: American Medical Association, 1970).

[6] "The Malpractice Threat: A Study of Defensive Medicine," p. 959.

The Secretary's Commission on Medical Malpractice has taken the testimony of numerous medical witnesses who have asserted that defensive medicine is practiced regularly by the medical profession. Apart from one or two witnesses who furnished actual statistics regarding these practices[8] the bulk of the testimony received has been of an unsubstantiated nature. The survey conducted by the American College of Surgeons and reported at the Malpractice Commission's Washington, D.C. hearing[9] illustrates the vagueness of this sort of testimony and its relative value. The same public hearing elicited information based on a survey conducted by the American College of Physicians, and although roughly half of the physicians surveyed indicated that they practiced defensive medicine, the witness, Dr. Edward C. Rosenow remarked, "I don't believe, really, that this is quite what they mean when they say it. . . ."[10]

It is amply clear that opinion surveys dealing with a phenomenon as subjectively oriented as defensive medicine are not likely to produce reliable statistics. The most recent such survey, conducted by the AMA and released at its recent annual convention, produced additional data of this calibre—in this case 70 percent of the physicians polled said they were practicing defensive medicine.

Defensive Medicine and Health Care Costs

If defensive medicine is practiced to any significant extent, it undoubtedly has added to the overall rise in health care costs. Some of these costs are direct costs passed on to patients and their insurers, while others are indirect costs resulting from misallocation of vital health care resources—manpower, facilities, and equipment.

The Duke study concluded that the lack of cost constraints in the existing health care system is a major cause of over-testing and overutilization of health care facilities, and that the fear of malpractice litigation plays a relatively minor role in this respect. In a 1968 interview, Dr. Charles L. Hudson, a past president of the American Medical Association, noting the availability of many new laboratory tests, commented, "We have become professionals of laboratory medicine. We rely on laboratory medicine. Students are taught in medical school to use everything available to them to find out everything about the patient."[11] Dr. Rosenow's testimony, mentioned earlier, appears to support this position.[12]

Notwithstanding the foregoing, there is growing evidence that physicians are in fact ordering more diagnostic tests than are probably necessary. In a study of 570 consecutive children admitted to a hospital emergency room for head trauma, the treatment of only one was altered as a result of the skull x-rays taken.[13] Hospital x-ray and laboratory procedures generally seem to be on the increase,[14] but once again, the lack of any hard data makes it difficult to draw definite conclusions about the relationship between defensive medicine practices and rising health care costs.

Conclusion

Intelligent discussion and analysis of the subject of defensive medicine is inherently beset with problems of definition, cause (motivation), and measurement. That the the phenomenon exists cannot be denied, but to say that all defensive medicine practices are invariably harmful, or that the threat of malpractice litigation is the only reason they occur, is much less supportable, based on the evidence at hand. Thus far, neither the Commission nor anyone else has been able to measure the extent of defensive medicine practices, making it difficult to assess its value as an indicator of the pervasiveness of the malpractice problem on a nationwide scale. The foregoing discussion has been an attempt to set forth the parameters of the defensive medicine issues.

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[7] Hershey, "The Defensive Practice of Medicine, Myth or Reality." p. 96.

[8] U.S. Department of Health, Education and Welfare, *Hearings*, before the Secretary's Commission on Medical Malpractice, Los Angeles, Calif., October 22, 1971, pp. 177-201

[9] U.S. Department of Health, Education and Welfare, *Hearings*, before the Secretary's Commission on Medical Malpractice, Washington, D. C., March 24, 1972, pp. 17-27.

[10] *Ibid*, pp. 146-165.

[11] "Better Medicine or Legal Medicine? This Big and Uneasy Feeling That Law Is Intruding," *AMA News*, Nov. 18, 1968, p. 14.

[12] U.S. Department of Health, Education and Welfare, *Hearings*, before The Secretary's Commission on Medical Malpractice, March 24, 1972, p. 150.

[13] "Child Head X-Rays: Value Doubted After a Study of 570 Cases," *Medical Tribune*, Vol. 11, No. 54 (Oct 26, 1970) pp. 1 ff.

[14] Anthony J. J. Rourke, M.D., "Are All Those X-Rays and Tests Really Necessary?" *Modern Hospital*, Vol. 118, (Jan. 1972), pp. 106-107.

MEDICAL INJURIES DESCRIBED IN HOSPITAL PATIENT RECORDS

John S. Boyden, Jr., LL.B., M.D.

Summary

This study was directed toward assisting in the determination of the feasibility of medical injury insurance which would compensate patients who are injured by medical management. Compensation would be payable to persons who are injured in the absence of fault, as well as to those who suffer negligently-inflicted harm.

One hundred patient records were reviewed in a hospital which has a complete staff of residents and interns. Three hundred records were reviewed in a hospital having no house staff.

Disability was rated in accordance with the rating scale which is used by workmen's compensation insurance carriers. In addition, disability was rated according to the degree of probability that it was caused by medical management rather than by illness.

The majority of injuries detected were side effects of treatment. Side effects of treatment are well-suited to the concept of medical injury insurance. Other types of injuries were much less common and required more detailed analysis than side effects.

The reliability of data obtained was limited by a lack of adequate follow-up information about the patients' condition after discharge from the hospital. Two cases of injury were not mentioned in the hospital record, but they were discovered in follow-up information which happened to be available for the patients involved.

The method used in this study appears to be suitable for a larger study which might be done on a sampling of records large enough to be considered representative of American medicine. Recommendations are made regarding the nature of the larger study.

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I. Statement of the Problem

The word "malpractice" connotes fault or bad practice. When a person is injured by medical treatment he is ordinarily not entitled to compensation unless he can prove that his injury was caused by the negligent act or omission of someone on the health-care team. Many observers of the malpractice scene feel that a cause-and-effect relationship exists between this burden of proof and the following, undesirable characteristics of our present system:

A. Payment of compensation is delayed beyond the time when the patients need it most; *i.e.*, when they are making their social and economic adjustments to their injuries.
B. Some persons who deserve compensation fail to assert their claims because they find it distasteful to blame their physicians for their injuries.
C. The system is expensive to operate. Attorneys' fees and fees for expert consultation are high. In addition, the defendant physician loses a great deal of time from his practice in preparation of his defense. The plaintiff, too, must spend a great deal of time in connection with his case.
D. Medical attention, even at its best, carries with it the risk that injury will occur in the absence of fault. Persons thus injured are compensated only partially, if at all, through health and disability insurance benefits.

This report describes a pilot study directed toward assisting in the establishment of the feasibility of a system of compensation for medical injuries which has the following characteristics:

1. Compensation would be payable to all who are entitled to it under our present tort system, but it would not be necessary to prove misconduct as a prerequisite to compensation.
2. Compensation would also be payable to persons injured by medical management in the absence of fault.
3. When a claim is reviewed, the issues raised could be readily decided by an administrative finder of fact in consultation with a panel of medical experts.
4. Many claims could be successfully asserted without the assistance of legal counsel.

If such a system can be devised, it has potential for minimizing some of the undesirable characteristics of the present system which are mentioned above and for expanding the scope of compensation to include persons in need of protection who do not presently enjoy it.

Immediate purposes of this pilot study are:

1. to examine a limited number of hospital patient records and identify and describe medical injuries which are documented therein;
2. to measure the frequency and severity of medical injuries so identified;
3. to outline the method used for medical record analysis; and
4. to devise or adopt a method for gathering and classifying data which can be used in a larger, follow-up study.

Data from a larger, follow-up study would have at least two uses:

1. they could be used to roughly estimate the cost of a system of medical injury insurance which may be proposed in the future;
2. persons responsible for improvement of medical care could use them to detect weaknesses in the health-care delivery system.

Contrary to our present-day concept of compensation for negligently-inflicted harm, the proposed concept of compensable medical injury is not intended to serve as a deterrent to negligent practices. If the proposed concept were implemented, it could easily be coupled with a quality assurance program, several of which are now in the planning stages.

One major limitation of the concept of medical injury insurance is the lack of a precise definition of medical injury for which compensation could be paid. The rather broad definition used in this pilot study is:

> "A medical injury is a disability caused by medical management."

The term "medical management" includes both affirmative acts and failures to act, but it does *not* imply that the management was necessarily improper.

Disability, in a broad sense, means to be deprived of normal functioning. In a medical injury context, disability has many forms including physical and mental impairment, disfigurement and "pain and suffering." Often, several forms are present in a single injury. The disability rating system employed in this study takes into consideration the combined effects of these various forms of disability.

Throughout the study, efforts were made by the investigator and by others who were conducting similar studies to more precisely define a medical injury. Numerous definitions were considered, but none was found to be completely satisfactory. It is natural to suspect that if investigators were to use the very broad definition of medical injury stated above, they could analyze the same cases and produce widely differing results. It was reassuring to find that there was only an occasional difference of opinion when specific cases of possible medical injury were evaluated by investigators in group discussions.

Medical injuries can occur as a result of physician misconduct (fault). *Medical injuries can also occur in the absence of fault.* A simple, illustrative example is a comparison of two patients each of whom experienced a disabling allergic reaction to a penicillin injection. One patient had taken penicillin on prior occasions without experiencing any adverse effects. The other patient had suffered shortness of breath and skin rash on a previous occasion and the notation "allergic to penicillin" appeared in large, prominent letters on the jacket of his medical record. Both patients contracted streptococcal pharyngitis. Their physicians ordered penicillin injections and both patients suffered disabling allergic reactions. In the first case, there was not physician misconduct, yet the patient suffered a medical injury because it was the treatment instead of the disease which caused his disability. In the second case, the physician was negligent in that he knew, or should have known, that his patient was allergic to penicillin. He probably could have prevented the allergic reaction by giving some other, appropriate drug. In this example, both patients suffered medical injury, but negligence was a factor in only one of them.

II. Method

A. CHRONOLOGICAL ORDER OF ACTIVITIES IN THE PILOT STUDY

The chronological order of activities in the pilot study was as follows:

1. Attempt to refine a working definition of a compensable medical injury. Discuss the definition with physicians and attorneys.
2. Attend hospital morbidity and mortality conferences to test the applicability of possible definitions to specific cases.
3. Consult with an actuary and other officers of an insurance company regarding data which should be collected in order to properly estimate the cost of compensating medical injuries.
4. Review various medical nomenclatures of disease for possible use in data processing.
5. Consult with a data processing expert regarding handling of data arising out of the pilot study.
6. Test the accuracy of the medical records in the department of surgery in a hospital having a complete staff of residents and interns by examining patients and comparing observed conditions with entries in the medical charts.
7. Review 100 consecutive hospital records from the department of surgery in the hospital having a complete staff of residents and interns.
8. Discuss specific cases with other investigators who are conducting similar studies.
9. Review 300 consecutive hospital records in an "average medium-sized community hospital" which has no house staff.
10. Prepare a report regarding results of the pilot study.

B. DISABILITY RATING

It was originally thought that specific injuries might be described using a systematic numerical nomenclature of pathology. This proved to be an unworkable method because the systems of nomenclature which were studied were too complex and were primarily oriented toward description of disease. They were not easily used to describe the nature and severity of disability.

Hospital records routinely contain a blank space for designating the patient's occupation. It was originally hoped that information regarding occupation and estimated number of days away from work could be obtained from the hospital records used in this study. Unfortunately, information actually encountered in these hospital records regarding occupation was often either too general to be accurately classified or absent. Thus, the hospital records usually did not contain enough information from which the patient's lost wages could be estimated.

For the above reasons, it was necessary to adopt a more general classification of disability which would be easy for an investigator to apply to specific cases.

After consultation with insurance company officials and with an actuary who has had long experience in the workmen's compensation field, the classification system which appeared to have the most utility for this study was that system which is in general use in workmen's compensation. The system is easy to apply to specific cases and, in addition, the claims experience of workmen's compensation carriers can be used to estimate the cost of medical injury compensation systems which may be proposed in the future.

The following is the method used in this study for measuring the severity of an injury; it is an adaptation of the workmen's compensation method.

Severity of Injury

Death is designated as "5." Permanent total disability is designated "4." It includes cases involving the loss or loss of use of both hands, both arms, both feet, both legs, both eyes, or any two thereof.

Permanent partial disability is (a) any permanent injury which does not involve permanent total disability or (b) any "temporary" case where the disability benefits exceed or are expected to exceed one full year. Permanent partial disability was further divided into major and minor cases. Major cases are arbitrarily defined as those estimated to exceed the value of $5,000. *Major cases are designated "3." Minor cases are designated as "2."*

Temporary total and *temporary partial* disability are designated "1." They include cases which are expected to involve benefits and which do not constitute cases of death, permanent total or permanent partial disability. These cases were recorded although the benefits payable in many of them are expected to be trivial. This is a significant group, however, because it is possible to have a temporary total disability requiring payment of substantial medical expense and lost wages.

Cases in which *no disability* was detected or in which the investigator felt that there was *no worthwhile issue of causation* were designated as "0."

No attempt has been made to identify the specific person or thing which actually caused a particular injury. Although identification of the source of disability was a part of the original proposal, early experience revealed that such identification was often speculative. It was also provocative and it tended to arouse the suspicion of hospital administrators and physicians.

C. CAUSED BY MEDICAL MANAGEMENT

Disability was further classified according to the degree of probability that it was caused by medical management. It was useful to roughly classify issues of causation into four categories:

Disability *definitely not caused* by medical management was designated "A."

Disability *possibly caused* by medical management (less than 50 but greater than 0.0 percent probability that medical management caused the disability) was designated "B."

Disability *probably caused* by medical management (greater than 50 but less than 100 percent probability that medical management caused the disability) was designed "C."

Disability *definitely caused* by medical management was designated "D."

If a disability is rated on a data gathering sheet as "3/C," it is a major, permanent, partial disability which was probably caused by medical management.

It will be noted that, if the investigator has already classified as "O" on the disability scale the cases in which he has found no worthwhile issue of causation, there is logically no need for the classification "A" on the issue of causation. Category "A" was sometimes used in the pilot study because this investigator felt that certain disabilities should be recorded for purposes of discussion. All deaths encountered in the records surveyed were entered on the data gathering sheets as "5-A" rather than "O" if the investigator felt that the death was not caused by medical management and that it was very unlikely that others would take issue with this opinion. Also, certain unusual disabilities found in the hospital records were similarly recorded, although the investigator was of the opinion that they were definitely not caused by medical management and that it was very unlikely that others would disagree with this opinion. The "A" category might well be deleted from a larger, follow-up study.

D. CHARACTERIZATION OF CLASSES OF INJURY

Characterization of injuries as "side effects of treatment," "failure to diagnose," "failure to treat," "hospitalization not indicated," "treatment not indicated," and "other" provides information as to whether the concept of compensable medical injury will be more convenient to administer than our present tort concepts. Side effects of treatment are generally easy to deal with because they result from easily identifiable events. The other categories sometimes require careful analysis similar to that required on the issue of negligence under our tort system. If the great preponderance of injuries are side effects of treatment, the concept of medical injury compensation may be much more convenient to administer than our present system.

E. NET OCCURRENCE RATE

The last two columns on the data gathering sheet designate whether the injury occurred in the hospital or was referred to the hospital after it occurred. They also designate whether the injury occurred during that admission which was selected for study or during a previous or subsequent admission. During this pilot study, evidence was found of medical injuries which had occurred during previous or subsequent admissions or which had occurred outside the hospital before being referred to the hospital for treatment. These injuries were recorded on the data gathering sheets. It is desirable to record them, but they should be set apart from the others. A major purpose of a larger, follow-up study could be to measure the rate of occurrence of compensable disability per unit number of hospital admissions. In computing this occurrence rate, only those injuries which occurred during the patient admissions selected for study should be counted. Patient records often contain information pertaining to more than one hospital admission. Medical injuries which are documented in a patient record, but which occurred during previous or subsequent admissions should not be counted, because they tend to inflate the number of injuries occurring per unit number of admissions. Only those injuries designated "I" *and* "T" on the last two columns of the data gathering sheets should be counted in the computation of the net occurrence rate. Net occurrence rates for this pilot study are not included in this report because the sample size is so small that the observed rates may not be representative of the hospitals studied.

F. TECHNIQUE FOR PATIENT RECORD ANALYSIS

In addition to specialist consultation, patient record analysis was substantially aided by the *Book of Norms* published by the Metropolitan Health Care Foundation of Minneapolis, Minnesota. These are somewhat general guidelines regarding indications for admission, probable length of stay, some complications which may extend the length of stay, indications for discharge, services recommended, and indications for transfer to extended care facilities. The technique which seemed to be most useful in patient record review is as follows:

1. Was the length of stay within normal limits for an uncomplicated case? Compare *Book of Norms* with actual length of stay. This is a very valuable indicator. If length of stay is prolonged, the chances are increased that there is a compensable disability.
2. Watch for a reference to "complications" in the discharge summary, progress notes and nurses' notes.
3. Carefully examine all progress notes and nurses' notes for patient complaints and for other evidence of disability.

4. Scan temperature, pulse and respiration charts, laboratory slips and x-ray reports for abnormal values which may give indications that an injury has occurred.
5. Review incident reports, if available. These reports may refer to injuries.
6. Was the hospital admission indicated? See the initial workup, the *Book of Norms* and the discharge summary.
7. Was the treatment medically indicated? Was other treatment indicated, but not given? These questions can usually be answered only after review of the entire record. The *Book of Norms* and specialist consultation are very helpful in this area.
8. If available, examine notes regarding clinic visits following discharge from the hospital. These notes will sometimes contain complaints of inability to return to work, infections, etc., which may not appear elsewhere in the record.
9. Subsequent admissions. If selection of patient records is based upon the date of admission, there may be subsequent admissions recorded in the patient's chart which contain reference to disability caused by medical management during the admission selected for study.
10. Delay in diagnosis. Did disability result from delay in making a correct diagnosis?

After disability has been found, the severity is rated on the scale of 0 through 5 which was described earlier in this report. The disability is then rated on a second scale "A" through "D" according to the degree of probability that it was caused by medical management.

G. RECORDING OF DATA

Information was recorded on data gathering sheets. For this pilot study, data processing was deemed inappropriate due to the limited number of cases examined and because it was desirable to record a specific medical description for each case. These specific descriptions were useful in the pilot study for discussion purposes. In a larger, follow-up study, it may be desirable to "pigeon hole" diagnoses and disability descriptions into a limited number of numerical classifications. General comments would probably be unnecessary in a larger study where it would be the primary objective to obtain data regarding the frequency and severity of medical injuries.

H. TESTING RELIABILITY OF DATA SOURCE (HOSPITAL RECORDS)

The accuracy of the charting habits of the doctors and nurses in the hospital having a complete staff of residents and interns was tested. Hospital records of 21 patients who were currently admitted to a surgical floor were examined. An impression of the condition of each patient was first obtained by examining his records. Each patient was then interviewed on doctors' work rounds and the patient's condition was discussed with the residents, interns, and attending physicians who were familiar with the case. A brief physical examination was also conducted on each patient. More than 95 percent of the observed disabilities were documented in the hospital charts. Only an occasional, mild superficial thrombo-phlebitis at the site of intravenous infusion was not mentioned in the charts. Data from the initial 21 charts were not entered in the data gathering sheets because each patient's hospitalization was not yet complete and because it had not yet been decided what data should be obtained. The extremely high correlation between disability noted in the records and disability noted from observing the patients applies only to the 100 consecutive charts examined from the Department of Surgery in the hospital having a complete staff of residents and interns. One of the conditions upon which examination of the 300 charts was allowed by the private hospital was that patients would not be examined by the investigator. Thus, no conclusions can be reached as to the reliability of the private hospital charts.

III. Results and Discussion

A. DISCUSSION OF RESULTS LISTED IN TABLES

Table I depicts the distribution of recorded disabilities for which there is a greater than 50 percent probability of being caused by medical management. These are the disabilities which can most probably be called medical injuries. They are listed by injury type and by incidence and severity of each type. Data from both hospitals are combined because the small sample size prevents meaningful comparison. A larger, follow-up study might reveal different occurrence rates for either or both of these hospitals. Also, it seems desirable to combine in one table all observed conditions which can probably be called medical injuries.

Of the 27 disabilities listed, 14 were found in the one hundred (100) charts examined in the hospital having a full staff of residents and interns. The remaining 13 disabilities were found in the 300 records surveyed in the community hospital which had no house staff.

Of the 22 disabilities rated "1," at least 12 are trivial; that is, they would be compensable in theory, but are of little value.

Of the three disabilities rated "3," two occurred in female patients over 65 years of age and one occurred in a male patient over 65. The cost of compensating these older patients would not be as great as the cost for younger persons because loss of wages and the length of time during which the disability is expected to exist are minimized by age. Although permanent partial disabilities have the potential for being very costly, those which were found in the pilot study were not of the catastrophic variety.

Of the two deaths, one patient was 58 years old. The other was 55. Both patients had major, primary disease which limited life expectancy. Several unmeasured factors may have contributed to the variation in the rates of occurrence between the two hospitals. As mentioned above, the samples cannot be considered representative of either hospital. A larger study might show different occurrence rates. In addition, it was this investigator's distinct impression that the average patient in the Department of Surgery was more seriously ill and needed more aggressive treatment than the average patient in the hospital having no house staff. It may be tentatively presumed that more aggressive treatment carries with it a higher risk of injury than treatment given to the less seriously ill patients.

TABLE I

DISTRIBUTION OF INJURIES
(Causation rated "C" or "D")

SEVERITY OF INJURY

INJURY TYPE	Injury incidence	1	2	3	4	5 (Death)
Burn	1	1				
Transient stroke	1	1				
Radiation	1			1		
Urine retention or infection	5	5				
Other infection	2	2				
Hospitalization not indicated	1	1				
Pulmonary embolus	2	1				1
Pneumothorax	2	2				
Pneumonia	1	1				
Medication or transfusion	2	1		1		
Drainage or hemorrhage	3	2				1
Chemical irritation	2	2				
Bowel perforation	1			1		
Post op. ileus or obstruction	1	1				
Nerve damage	1	1				
Transient jaundice	1	1				
TOTAL	27	22	0	3	0	2

Table II depicts the distribution of the relatively small group of "borderline" cases in which it was felt that there was less than a 50 percent probability that medical management caused the disability. These cases are called disabilities rather than injuries to call attention to their borderline nature. Of the seven disabilities listed, five occurred in the hospital having house staff (100 charts) and two occurred in the community hospital (300 charts).

TABLE II

DISTRIBUTION OF DISABILITIES
(Causation rated "B")

SEVERITY OF DISABILITY

DISABILITY TYPE	Injury incidence	1	2	3	4	5
Pulmonary Embolus	1	1				
Urine retention or infection	1	1				
Other infection	1	1				
Thrombo-phlebitis	1	1*				
Respiratory distress in premature infant	1					1
Post op. myocardial infarction	1					1
Post op. cardiac arrhythmia	1	1				
TOTAL	7	5	0	0	0	2

*Severity not documented.

Table III summarizes injuries for which documentation was found in the charts, but which occurred outside the hospital or during an admission other than the one being studied. These injuries are separated from the others in order to allow calculation of the net occurrence rate mentioned earlier in this report.

Table IV groups the causes of injury into descriptive categories called "types of cause." All cases reported in Tables I, II, and III are characterized in Table IV as "side effects of treatment," "failure to diagnose," "failure to treat," "hospitalization not indicated," "treatment not indicated," or "other." Forty of the 45 disabilities observed were side effects of treatment. For reasons mentioned in subparagraph II D above, these data indicate that the concept of medical injury compensation may be more convenient to administer than our present system. *Although all of the charts examined were at least 14 months* *old, no claims have been threatened or asserted for injuries listed in this report.*

TABLE III

DISTRIBUTION OF INJURIES REPORTED IN CHARTS, BUT SUSTAINED BEFORE OR SUBSEQUENT TO THE ADMISSION BEING STUDIED

		DISABILITY RATING				
INJURY TYPE	Injury incidence	1	2	3	4	5
Urine retention or infection	2			1		1
Other infection	1			1		
Wound infection	1	1				
Failure to diagnose	1					1
Structural failure of surgical repair	4	2	1			1
Post op. bowel obstruction	1			1		
Medication	1	1				
TOTAL	11	4	1	3	0	3

TABLE IV

DISTRIBUTION OF INJURIES BY CAUSES (for Cases Reported in Tables I, II and III)

		DISABILITY RATING				
TYPE OF CAUSE	Incidence	1	2	3	4	5
Side effects of treatment (including structural failure of surgical repair)	40	30	1	6		3
Failure to diagnose	1					1
Failure to treat (including progression of disease in presence of inadequate treatment; also failure to supervise, such as patient falling out of bed)	3					3
Hospitalization not indicated	1	1				
Treatment not indicated	0					
Other (including negligence not otherwise compensable)	0					
TOTAL	45	31	1	6	0	7

B. FACTORS WHICH TEND TO LIMIT THE ACCURACY OF THIS PILOT STUDY

1. Lack of adequate follow-up information on patients whose charts were reviewed weakened the reliability of the study. Whenever a patient had been admitted to the same hospital subsequent to the admission being studied, the subsequent records were also reviewed. Two injuries sustained during the admissions being studied were found in subsequent admission records. There was no mention of these injuries in the record which covered the time when they were sustained. If these patients had been hospitalized elsewhere, the disabilities would have gone undetected.
2. Another significant limitation of the pilot study is that the doctors and nurses who made entries in the charts did not have their attention directed toward evaluation of disability. If the suggested larger study were to be prospective, hospital personnel and physicians participating in the study could be instructed as to the nature of the information which the study seeks to obtain. This could result in more precise descriptions of injury than might otherwise be available.
3. In the community hospital the investigator was not able to make personal comparison between a patient's actual condition and the information contained in the patient's hospital record; therefore, the accuracy of charting habits of personnel in the community hospital was not evaluated.
4. Data obtained in larger, follow-up studies might eventually be used in conjunction with workmen's compensation claims experience to estimate the cost of a system of medical injury compensation; however, the method used in this study for recording data tends to document disability in excess of that for which compensation might eventually be paid be-

cause it measures the entire resulting disability and not merely the difference between the patient's condition before and after the injury. For example, a person may initially have a minor, permanent, partial disability; medical management may cause another minor, permanent, partial disability, but the total impact on the patient may be a major, permanent, partial disability. To avoid underestimating the severity of a medical injury, the total impact which that injury has upon the patient was measured.

This investigator is advised by insurance company officials and actuaries that workmen's compensation cases in which new disabilities are superimposed upon pre-existing disabilities are handled differently from state to state. If it were decided that a proposed system of medical injury insurance would compensate only the difference between the new disability and the pre-existing one, the lumping together of the workmen's compensation claims experience of all states should minimize the inaccuracy of the cost estimate caused by the method used to document disability in this study.

C. MISCELLANEOUS DISCUSSION

It must be remembered that the injuries depicted in Tables I and II represent the risk of harm from medical management. Some persons accustomed to working within our present tort system have incorrectly surmised that, when a patient's disability is "caused" by medical management, there is something "wrong" with the way in which the patient's case was handled. This is not necessarily so. The correct view is that disabilities can be caused by medical management even when there is nothing "wrong" with the management of the patient's condition.

The proposed concept of medical injury compensation does not eliminate the need for findings of fact and for expert opinion; however, the issues raised would usually focus attention on the nature and etiology of the disability and not upon the conduct of the health-care team. It would seem that many cases could be decided by testimony of the claimant, by review of the hospital or physician's office record and by consultation with members of an expert medical panel. This would minimize the need for examination and cross-examination of the treating physician. Compensation in some cases could probably be paid without any hearing or formal proceeding.

The pilot study is not designed to obtain data which could be used directly to predict the actual workload of an agency charged with administering a proposed compensation system. That workload would depend primarily upon the number of claims filed and would only be indirectly affected by the frequency of medical injuries. Data obtained in this study regarding the frequency and severity of medical injuries could be used to estimate the number of *valid* claims. In basing a cost estimate of any medical injury compensation system upon the claims experience of workmen's compensation carriers, the assumption is necessarily made that, in the future, persons covered by medical injury insurance will exhibit the same degree of claims-consciousness as persons who have heretofore been covered by workmen's compensation insurance. A review of hospital records gives no information as to the frequency and severity of medical injury occurring in the physician's office. A larger, follow-up study should include a significant sample of physicians' office records.

IV. Conclusions

A. Conclusions drawn from the data obtained in this pilot study must necessarily be only tentative. The sample was small and hospital charts were selected in one hospital in a deliberate attempt to produce an inflated rate of medical injury. This was done in hopes of obtaining more case material for discussion than might otherwise be available.

B. The definition of medical injury needs refinement.

C. Experience during this pilot study tends to indicate that the methods described herein for gathering and classifying data will be useful in a larger study. Although only one investigator participated in this pilot study, it is reasonable to assume that the methods devised would minimize the differences in professional opinion among investigators in a larger study.

D. *If* the results of this pilot study are verified by a larger study, most medical injuries are side effects of treatment. Side effects are especially suited to the concept of medical injury compensation.

E. The reliability of an estimate of the cost of medical injury insurance premiums based upon data obtained in larger studies similar to this pilot study would be limited by several factors which are listed above in the discussion section.

F. Some of the injuries listed in the data gathering sheets are legitimate subjects for litigation under our present system. The fact that no claims have been threatened or asserted for any of them tends to indicate that patients are unaware that they may have claims or else that they do not wish to press them.

V. Recommendations

A. Conduct a follow-up study. Give careful consideration to the following:
   1. Select a sample of records which is large enough to be considered representative of American medical care.
   2. Select medical records on a random basis, but utilize a substantial number of records from institutions where post-discharge, follow-up information is incorporated into the medical record.
   3. Give the study a prospective flavor by notifying persons responsible for making entries in the medical records that the study is in progress. These same persons should be instructed in methods for docu-

menting severity of disability and for making meaningful entries regarding prognosis for the disabilities observed.

4. Check the accuracy of the charting habits of hospital personnel whose records are involved in the study.
5. Check the chart analysis techniques used by investigators prior to beginning the larger study in order to insure uniformity of results.
6. Include a substantial number of records from physicians' offices.

B. Prior to executing a follow-up study, submit the data obtained in this pilot study to selected insurance companies and/or other persons with insurance premium rate-setting expertise. Ask them to compute premiums for medical injury insurance and to document their methods of computation. This exercise would produce valuable insight regarding the adequacy of data obtained in this pilot study. Data gathering techniques could be modified to remedy any inadequacies found.

C. If data from a larger study indicate that the probable cost of medical injury insurance premiums is not prohibitive, a model compensation system should be tried in a limited geographic area. The Federal Government or some other source of funds could agree to meet the risk that the cost of the pilot system might exceed its premium revenue.

D. The time required to review medical records and to prepare this report was substantially underestimated. In estimating the cost of future studies, approximately one hour per chart should be allowed for examination of records and discussion of findings. Additional time should be allowed to coordinate a larger study and to carry out functions characteristic of the larger study such as preparation of a data processing nomenclature for diagnoses and injuries, statistical analysis of data, and correlation of data obtained with workmen's compensation claims experience. Other additional time should be allowed for preparation of a written report.

THE INCIDENCE OF IATROGENIC INJURIES

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Summary

In this study of the incidence of iatrogenic injuries, somewhat more than 800 medical records were examined by two medical-legal experts at two hospitals which were chosen to be reasonably representative of American hospitals. The principal random sample of medical records was drawn from adult medicine, surgery, and gynecology cases, which accounted for more than 80 percent of all patients in the hospitals during the period under study. The overall sampling rate was close to 16 percent. Data were abstracted from the medical records, and the reviewers completed a questionnaire for *each case* alleged to be an injury. Statistical analyses, performed to determine the "goodness of sample" on the basis of average length of stay, age distribution, and distribution by hospital service showed that the sample was representative of the population from which it was drawn (i.e., all hospital discharges).

Ninety cases were initially identified by the reviewers as (iatrogenic) injuries. These injury cases were then further examined by the original reviewers plus an additional medical-legal counsultant. Of the 70 injury cases that remained after that meeting, several were still questionable and were further discussed in a final panel meeting which included two additional medical consultants. The final number of cases determined to involve injuries was 62. No effort was made to reexamine the cases that were initially rejected as non-injuries, although subsequent findings indicated that some of these cases may well have been injuries that were overlooked. Hence, the final injury figure can be said to be a lower bound.

In addition to the random sample, a control sample containing records, identified by hospital incident reports or previous claims, was drawn and intermixed with the random sample. The purpose was to establish a measure of the reviewers' "miss" rate in assessing injuries. The reviewers only identified about 60 percent of these records as injury cases.

Data associated with the injury cases were to provide additional information relating to the cause and nature of the injuries. These data included average length of stay, age distribution, service distribution, evidence of injury (charts, reports, etc.), source of injury (personnel), severity of injury, and classification of injury. The results are indicated briefly below. The average stay for injury patients was substantially longer than that for the random sample patients generally. The most frequent initial evidence of injury was in laboratory reports, progress notes, vital sign graphic charts, and operative notes. Attending physicians were by far the largest personnel group specifically associated with injuries by the reviewers. Although most injuries were temporary in nature, eight resulted in death. More than 65 percent of the injuries were due to post-operative complications. Age, service, and length of stay are all strongly related to the injury detection rates, but the underlying causal relationship has not been established.

Those injury cases for which the reviewers ascribed the injury to negligence were subjected to further analysis.

Final results indicated an overall patient injury rate at the two sample hospitals of approximately 7.5 percent. This figure, due to the methods used in the study, represents a lower bound on the true injury rate.

Finally, making use of the available data and the above results, projections for both hospitals (combined) were made for the estimated 23,750 patients discharged during 1972. The projections indicate that:

- 1,780 patient injuries occurred
- 517 of the injuries were due to negligence
- 31 claims will be filed against the hospital or medical staff on behalf of patients discharged during the year.

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The methods developed successfully supported a study of patient injuries in the hospital setting. The techniques, modified on the basis of the experience gained, should be applied on a wider scale in the future.

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Section I
Introduction

Heretofore, the principal focus on the malpractice issue has been on claims and associated high awards to plaintiffs, and the resulting high insurance premiums. The Commission felt that it could not concentrate on these facets only; that it was also necessary to examine the basic underlying source of malpractice claims. The major thrust of this study, therefore, was directed toward the *quantification* and analysis of those elements of the health care delivery system that bear directly on how and why injuries that precipitate malpractice claims occur. Additional motivation lies in previous reports that "unfortunate sequelae and accidents attributable to sanctioned and well-intentioned diagnosis and therapy were noted in about five percent of patients admitted to medical wards." (Barr 1955.)

This report describes how the following questions were addressed, and the answers obtained.

- What procedures should be used in medical records review?
- What instruments should be developed (for reviewing medical records)?
- What is the rate of injury detection that can be expected from the medical records check?
- How can the medical-legal experts be utilized with maximum effectiveness (i.e., the method of selecting records to be reviewed)?

The report is essentially a description of a test of one set of answers to these questions and the results thereof. The procedures actually used in the medical records review are described, including the functioning of the medical-legal experts (Section II). The data related to the incidence of reported injuries are presented in Section III.

It was necessary upon initiation of this study to adopt a working definition of iatrogenic disease. The definition adopted was essentially the one proposed by Burgess (1965), i.e., a disease caused by "errors of omission or commission as may be directly or indirectly caused by able physicians acting in accordance with modern medical usage,"; this definition was extended as proposed by Kampmeier (1966) to include the application of methods of diagnosis or treatment to the detriment of the patient's health or even the cause of death. Schimmel (1964) limits the definition to exclude discomforts not considered harmful to the patient but which are necessary in the usual course of current medical diagnosis and therapy. There was considerable discussion, bordering on disagreement, regarding an acceptable definition on the part of the participants in the study during its early stages. Upon review of the results of the study, and on the basis of observing the work of the medical-legal reviewers, these are essentially the definitions that have been applied in the identification of injuries in this study.

Section II
Method

SELECTION OF THE HOSPITALS

Particular care has been taken to maintain strict confidentiality of all information presented in this report. This applies to identification of the participating hospitals, as well as the identity of those patients whose records were examined. The participating hospitals were selected on the basis of six criteria:

- Non-profit
- Community-based general hospital
- In the 250-400 bed range
- Participate in the Professional Activity Study - Medical Audit Program of the Commission on Professional and Hospital Activities (PAS-MAP)
- Operate a training program (at least a residency)
- Operate an organized outpatient department.

These criteria were used to select hospitals that could be considered somewhat representative of the mainstream of American institutional health care.

The two large urban hospitals selected met all six of the criteria; both were short-term general medical/surgical hospitals. Each hospital operates a residency program, but no residents were on their staffs during the period covered by the medical record audit. Without the complete cooperation offered by the administrative staff, and particularly the medical record personnel, this study would have been impossible. The hospitals can be characterized by the data appearing in Table 1. Specific numerical data have been rounded off to prevent identification of the hospitals. The principal approvals and accreditations of each hospital are summarized in Table 2.

TABLE 1

PRINCIPAL CHARACTERISTICS OF PARTICIPATING HOSPITALS

Characteristics	Hospital	
	A	B
Number of Beds	250	290
Number of Admissions (1970)	10,000	12,000
Census (average over 12 months)	190	225
Occupancy Rate	76%	80%
Number of Full-Time Equivalent Personnel	770	860

TABLE 2

APPROVALS OF PARTICIPATING HOSPITALS

Approval	Hospital	
	A	B
Joint Commission on Accreditation of Hospitals	X	X
AMA-approved Residency	X	X
AMA-approved Internship	X	–
Professional Nursing School Reported by National League of Nursing	X	X
Blue Cross	X	X
Medicare Certified	X	X

Although it is not appropriate to attempt to describe two hospitals as totally representative of all hospitals in the United States, it is worthwhile to ask whether they are typical. Of the total of 5,994 short-term general hospitals reported by the American Hospital Association, 3,243 are in the same class as Hospitals A and B with respect to control: "non-governmental not-for-profit." The average occupancy for all hospitals in the same size range was 81 percent. Thus, it is reasonably accurate to characterize the two hospitals selected for the study as not atypical of hospitals in the United States.

SELECTION OF THE RECORDS FOR REVIEW

The medical records selected for review fall into two major groups. A random sample was selected, as well as a set of control cases that had received prior attention for reasons related to possible injury.

Selection of Random Sample

Several approaches to the selection of a set of records for review were considered initially. One approach was to examine only those cases where death occurred in the hospital. Another was to seek records in which the length of patients' hospital stays exceeded the norms. Several other schemes designed to enrich the sample (i.e., provide more than the random occurrence of injuries) were discarded. The wisdom of this choice was not as apparent when originally made as it is now, upon completion of the study. One reason for this is that the adoption of any such scheme would have made extrapolations from the results virtually impossible. The final decision was to simply select a set of records at random; however, only specific services were sampled in the random selection. These services were medicine, surgery, and gynecology. Thus, obstetrics, pediatrics, emergency room, etc., patients were excluded. Relatively low injury rates were predicted for obstetrics and pediatrics. Further, some hospitals do not maintain a pediatric service, so that the three services selected were considered common to all short-term hospitals. Overall, the percentage of discharges from the services included is approximately 82 percent for each hospital.

The mechanics of the random selection were essentially straight-forward. The basic selection of patient medical records was made from the hospital discharge lists for the three alternate months of January, March, and May, 1972. This provided a sample of recent, and thus readily accessible, records, and PAS-MAP summary reports were available for the months selected. The alternate months were chosen to cover a wider span of time than three consecutive months. Each entry on the discharge list is identified by a medical record number or an accounting control number. It was originally estimated that approximately 250 records from each hospital could be reviewed with the resources available. To provide for the possibility that this might be a significant underestimate, approximately 500 records in each hospital were selected initially. The technique was simply to first find every record number ending in the digit "0" on the discharge list that corresponded to a patient in one of the services being sampled. If the resulting number of records drawn was too small, the operation was repeated using all record numbers ending in the digit "5".

Selection of Control Sample

In an attempt to provide an independent test of the reviewers' performance, a set of control records was selected in addition to the random sample. The sample of control records was drawn on the basis of information made available by the hospital administrators. These records belonged to two major subcategories: (1) those records for which a member of the hospital staff had filed an incident report, describing an injury to a patient, and (2) those records for which a claim was made against the hospital or medical staff, including records released by subpoena as an initial or subsequent event in the processing of a claim for an injury. The control records were reviewed by a medical-legal consultant who was not one of the two project record reviewers; in his opinion, every record in the control sample contained evidence of patient injury. It should be noted, however, that in his review of the records, he knew the source of each record. It should also be noted that most of these records were from a period earlier than those in the random sample. For this reason, a limited number of records were selected at random from the period covered by the control sample and included in the random sample to prevent the reviewers from associating injury cases with a particular time period.

SELECTION OF REVIEWERS

The two experts (Reviewers A and B) who did the basic initial review of all records, the random sample and the control cases, were medical-legal specialists. Their usual professional activities involve the review of records and other data in connection with legal actions involving alleged malpractice. A similarly qualified consultant participated in the program as medical-legal consultant to the GEOMET staff. As will be discussed in Section III, two additional consultants served as panel members in a final review of the injury cases. The panel members were board-certified specialists, one in internal medicine, and one in surgery. Both physicians actively see patients and provide care in hospital settings.

DESIGN/CONDUCT OF THE EXPERIMENT

Sequence of Events

An initial planning meeting was held that included GEOMET staff members, the two reviewers, GEOMET's medical-legal consultant, and the Malpractice Commission's Director of Research. At this point, the form to be completed by the reviewers was finalized, and a decision was made to select a random sample of records for review. Neither of the record reviewers was told that his sample would include several records from the administrator's file at each hospital (the "control" records). The original plan was to have each reviewer check half the records in each hospital in an effort to eliminate any correlation between the reviewers' performance and the hospital. For various logistic reasons, this proved to be impossible. Instead, one reviewer checked approximately 425 records in one hospital, consisting of approximately 400 randomly selected records and 25 control records. The second reviewer repeated this procedure in the other hospital.

It was originally planned to have each reviewer examine a sample of the records that had been previously examined by the other reviewer (the "cross-check" sample). Reviewer B did check 50 records previously examined by Reviewer A, but the planned reciprocal operation did not take place because of the illness of Reviewer A.[1]

Conduct of the Review

GEOMET staff members worked with medical records personnel in each hospital to obtain actual records corresponding to the record numbers that had been drawn at random from the discharge lists, as well as the control sample. For each record drawn, a Medical Record Abstract form, shown in Appendix A, was prepared; GEOMET staff members completed the entire form except the portion concerning the identification of the record as an injury case, which was completed by the reviewer. If his answer to the question, "Has an injury occurred?" was "Yes," he was asked to complete the Injury Report form shown in Appendix A. In addition to gathering specific injury data, the Injury Report form was used to record the reviewer's opinion as to whether or not the injury resulted from negligence. The completed forms then became the source of basic data used in the analyses reported here.

Review of Injury Cases

A meeting was held after completing the initial review of approximately 400-425 records in each hospital and the cross-check sample. This meeting (referred to as the "review meeting") included the two reviewers, GEOMET's medical-legal consultant, and GEOMET staff members. At this time, all cases that had been identified as injuries were discussed by the three medical-legal experts. In almost all instances, the discussion centered around the issue of whether or not the case was indeed an injury.

The major outcome of this meeting was that some of the cases initially identified as injuries were eliminated. Essentially, no attempt was made to review the cases that each reviewer had previously decided were non-injuries. In the case of the cross-check records, however, several of the cases that Reviewer A had deemed "no injury" had been identified as injuries by Reviewer B. In four of these cases, Reviewer A indicated that he had made a mistake and that they were indeed injuries. In the analysis presented below, these cases are excluded on the basis that only those injuries that were initially identified by one of the reviewers were counted.

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[1] Since the reviewers worked independently, the order in which they examined the cross-check sample of records is irrelevant. The cross-check records thus constitute a reliability measure for the reviewers' work. They do not, however, help us understand how dependent the inter-reviewer reliability is on the individual hospitals, or on the quality of the medical records.

At the meeting, several cases were identified as requiring additional consultation. On the next day, a "panel" meeting was held which included the three medical-legal experts, GEOMET staff members, and the two additional consultants (the board-certified internist and the board-certified surgeon). At this meeting, "problem" cases were reviewed and firm decisions were made as to whether each should be counted as an injury. As in the case of the review meeting, the panel meeting did not consider cases that had previously been deemed non-injuries.

The results of the successive reviews were always in the direction of reducing the number of injury cases. Those cases finally retained in the injury file were those on which a consensus was reached by all five physician panel members.

Section III
Results

This section of the report presents the principal results of the study. The first major subsection describes the results associated with the main thrust of the study: the examination of a random sample of hospital records. Injury-rate results are presented, as well as several statistical analyses of the injury data. Subsequent subsections deal with other aspects of the injury detection effort. The final portions of this section of the report contain comparisons of the injured patients with those represented by the sample of randomly selected records, as well as a comparison of the sample of records drawn at random with the population from which it was drawn, i.e., all of the hospital patients.

INJURY RATE

The results of the review of the random sample of medical records are summarized in Table 3. This table shows the number of records in the random sample initially judged to be injury cases, and those that were still so considered as a result of a consensus reached at the review meeting, and the panel meeting, respectively.

The results shown in Table 3 indicate that the final accepted rate of injuries for Hospital A was 6.4 percent, for Hospital B it was 8.8 percent. In both cases, the number may be considered an estimate of the lower bound on the injury rate since the review proceedings permitted only the acceptance or rejection of a case previously judged to show evidence of injury. That is, essentially no effort was devoted to dealing with those cases that had initially been classified as non-injury. Thus, the results of the review and panel meetings could only maintain or reduce the original injury rate.

At the review meeting, attended by the two initial reviewers, GEOMET staff members, and GEOMET's medical-legal consultant, every case previously judged to be an injury was reviewed. "Definitional problems" were also discussed; these centered around the question of differentiating between anticipated events during the course of therapy in a hospital setting, and avoidable and unavoidable injuries.

Of the 90 cases first evaluated as injuries by the reviewers, 70, or about three-quarters, were unanimously rated as injuries upon review at this meeting. The other cases were either rated as non-injuries or deferred for additional review at the panel meeting. Cases eliminated included several where the medical record indicated that equivocal circumstances were associated with the patient discharge, but no evidence of any untoward consequence appeared in the record.

Two cases were identified for further study of the medical record by Reviewer B, and the medical records were subsequently reexamined at the hospital. One of these was considered an injury upon the second check of the medical record. Two cases originally evaluated as noninjuries by Reviewer B were classified as injuries during the meeting, but these are not included in the totals reported here.

The 25 cases on which a consensus could not be reached were scheduled for presentation to the additional medical consultants at the panel meeting. These cases included postoperative thrombophlebitis and pulmonary embolism, possible errors of diagnosis in pathology, and indications for oophorectomy or hysterectomy. It may be noted that this meeting was held at one of the hospitals, and the availability of its medical records was an asset during the discussion. This is a point that may be considered worthwhile in conducting further studies of this type.

All 25 cases were discussed and, generally, those still considered injuries following the panel meeting were classified as such on the basis of unanimity among all five physician panel members. One of the cases upon which differences of opinion remained was finally dropped and classified as no injury. Special situations encountered in this review included:

- An injury related to a prior recent hospitalization
- A potential case of injury[2] classified as non-injury due to the absence of information subsequent to hospitalization
- A non-injury classification on the basis of insufficient information during the hospital stay.

ANALYSIS OF FINAL RESULTS

The distribution of diagnoses among the injury cases is such that no statistical analysis of the data appeared worthwhile on this basis. The results can, however, be grouped in several major categories of injury type. The number of cases in each of the major injury categories may be summarized as:

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[2] Specifically, several discharges under certain circumstances (fever on discharge, potential wound infection, etc.) where the absence of post-discharge data or a short post-operative stay precluded a definite injury assessment.

TABLE 3

NUMBER OF CASES JUDGED TO BE INJURIES IN RANDOM SAMPLE OF MEDICAL RECORDS AT PARTICIPATING HOSPITALS

Hospital	Size of Random Sample	Number of Injuries			Final Injury Detection Rate
		Initial Review	After Review Meeting	After Panel Meeting	
A	422	40	31	27	6.4%
B	399	50	39	35	8.8%
A & B Combined	821	90	70	62	7.6%

- 40 post operative complications
  - 21 infections
  - 6 pulmonary embolism and thrombophlebitis
  - 13 other complications
- 9 adverse drug reactions
- 5 slip-and-falls
- 4 treatment errors
- 4 others.

Postoperative complications accounted for more than 65 percent of the injuries. The "other" category includes diagnostic errors, complications due to anesthesia, radiography complications, and equipment problems, each of which accounted for one injury case.

The data entered on the forms (Appendix A) by the reviewers were analyzed for all of the injury cases. The analysis was limited to quantitative information provided by the record reviewers, which was not complete in all cases. Each reviewer also dictated extensive notes for each injury case, but it was decided that, in order to maintain complete objectivity, no effort would be made by the study team to translate the comments into actual form entries.

The first question addressed in the statistical analysis was: "Are the injury rate results obtained in the two hospitals significantly different?" A difference of proportions test indicated that the difference in the final injury rates is not statistically significant, and this was further verified by a Chi-Square test. This is accepted as meaning that for many purposes all of the records judged to indicate evidence of medical injury after the panel meeting can be treated as one sample.

Negligence

In those cases in which an injury was judged to have occurred, the reviewers were asked to assess the likelihood that negligence had caused the injury. A further examination was made of all cases in which the reviewers answered "Yes" to the question, "Did negligence cause the injury?" Of the 62 injury cases in the random sample, 18 were judged to have been the result of negligence (9 from each hospital). However, although both reviewers expressed complete confidence that *an injury* had occurred in all of these 18 cases (see next section), they were not as confident that their *negligence* response was correct (an average score of 2.3 on a scale of 1 to 6). Characteristics of these cases are summarized in Table 4.

Although it appears that the average age in the *negligence* cases is quite high, it should be noted that this result is greatly influenced by the elderly (age 65 and older) patients in Hospital B, where 66 percent of the injury cases were in this age bracket. Seven of the eight deaths among the injuries are in the nine negligence cases in Hospital B. This result may be influenced by the relatively higher average age of the patients in Hospital B. The outcome of legal action as predicted by the reviewer in Hospital B tends to favor the plaintiff. Other parameters are similar to those for all injury cases. Because the number of cases is small, discretion should be used in drawing conclusions.

Reviewer Confidence in Injury Evaluation

The Medical Abstract form (Appendix A) provided a space for each reviewer to indicate whether an injury had occurred. It also asked for an indication of the reviewer's confidence in his answer, on a 6-point scale from "unsure" (1) to "confident" (6). A summary of these results appears in Table 5. Results for both reviewers/both hospitals were sufficiently similar that only the aggregate results are shown. The results indicate that, in more than 93 percent of the final injury cases, the reviewers were above the "unsure-confident" threshold (i.e., a score equal to or greater than 4). Here, only the cases where no entry was made were excluded. The most frequent entry was a score of 6 (confident) by an overwhelming majority.

It is also of some interest to seek a relationship between the reviewers' degree of confidence and the results of the review and panel meetings. For this purpose, the confidence scores were tabulated for all cases originally designated as injuries but later dropped as a result of one or both meetings. These results also appear in Table 5. The degree of confidence in identifying these cases as injuries is

TABLE 4

SUMMARY OF NEGLIGENCE DATA FOR RANDOM SAMPLE INJURY CASES

Hospital	Number of Cases	Average Patient Age (Years)	Average Stay (Days)	Most Common Category of Injury	Most Common Injury Source	Most Common Category of Severity of Injury	Average Predicted Legal Outcome*
A	9	46	13.3	Post-Operative Complications (7 of 9)**	Attending M.D. (3 of 3)**	Major Temporary (6 of 7)**	3.0
B	9	74	9.5	Therapy Error (3 of 9)**	Attending M.D. (5 of 9)**	Death (7 of 9)**	1.8
A & B Combined	18	61	10.5	–	Attending M.D.	–	2.3

*Scale of 1 - 5; 1 = plaintiff, 5 = defense.
**Number of cases reported as shown, out of all cases for which data were available.

also quite high. Of the entries made, approximately 75 percent are above the "unsure-confident" threshold. However, the results do show that the fraction of cases retained as injuries after the review and panel meetings is higher for the high-confidence cases than for the low-confidence cases. The fraction of cases retained and the confidence rating are strongly correlated.

TABLE 5

REVIEWERS' CONFIDENCE IN RATING INJURY

Injury Record Sample	Number of Cases						
	No Response	Confidence Rating*					
		1	2	3	4	5	6
Total Cases	13	1	1	7	8	3	57
Cases Dropped in Review/Panel Meetings	6	1	1	3	5	1	11
Final Injury Cases (Cases Retained)	7	0	0	4	3	2	46
Percent Retained	54	0	0	57	38	67	81

*Scale: 1 = unsure, 6 = confident.

Evidence of Injury

Each reviewer was asked to indicate the source of evidence which led him to evaluate a case as an injury. Although the reviewers were also asked to rank several sources in degree of importance, usually only one check was entered for one source of information. Again, the results for both hospitals are sufficiently consistent that only the aggregate results are presented in Table 6.

More than half the cases for which a source of evidence was noted (55 cases) were rated as injuries on the basis of the Laboratory Report (11 cases), Vital Sign Graphic Charts (8 cases), or Progress Notes (9 cases), in the context of the remainder of the record. These results are of some significance in guiding future studies of the same type. The final decision to rate a case as an injury was not based on any single report in the complete record. The reported sources of evidence should be viewed as an indication of the source that acted as the initial indicator, usually resulting in a reexamination of other portions of the medical record.

Source of Injury

In an attempt to pinpoint the types of personnel associated with the cause of injury, the reviewers were asked to indicate the "source of injury." A tabular summary of the results for both hospitals appears in Table 7. Approximately 70 percent of the entries ascribe the injury to the attending physician.

Severity of Injury

A summary of the ratings of severity of injury based on the scale adopted by the Malpractice Commission is shown in Table 8. Most of the cases were minor temporary injuries, although a total of 8 deaths were reported (all elderly patients in Hospital B). The average age of these patients was 83 for those on the surgical service, and 73 for those on the medicine service.

TABLE 6

REVIEWERS' REPORTED EVIDENCE OF INJURY

Source of Evidence	Number of Cases
Laboratory Report	11
Radiology Report	5
Pathology Report	1
Operative Notes	7
Autopsy	0
Consultant Reports	2
Nurses' Notes	4
Admitting Work-Up	4
Anesthetic Records	1
Vital Sign Graphic Charts	8
Progress Notes	9
Other	3
No Entry	7
Total	62

TABLE 7

REPORTED SOURCE OF INJURY

Source	Number of Cases
Attending Physician	30
Consulting Physician	1
Nurse	6
Aide	1
Pharmacist	0
Radiologist/Radiology Technician	0
Anesthesiologist	1
Pathologist/Laboratory Technician	0
Other/Unknown	3
No Entry	20
Total	62

TABLE 8

REPORTED SEVERITY OF INJURY

Severity of Injury	Number of Cases
Mental Injury Only	0
Temporary	
Insignificant	0
Minor	27
Major	19
Permanent	
Minor	1
Significant	2
Major	1
Grave	0
Death	8
No Entry	4
Total	62

Evaluation of Control Records

As described in Section II, a "control" sample of records was selected in each hospital from records in the administrator's file that were either associated with a hospital-generated incident report, or a legal authorization or subpoena to release the record in connection with a claim for injury against the hospital or medical staff. The results of the review of these records by the medical-legal experts are summarized in Table 9. All records initially rated as injuries have been included, since only two cases were later eliminated as the result of the review and panel meetings. In all, both reviewers identified only slightly more than half of the control records. These records were intermixed with the random records throughout the initial phases of the experiment. An independent review of these records reported clear evidence of injury in all of the cases. However, the GEOMET consultant conducting the review selected and knew the source of all records in the control sample; these factors may have influenced his evaluations.

The purpose of selecting the control cases was to establish a measure of the reviewers' "miss" rate in assessing injuries. The results of the initial review of the control cases, as shown in Table 9, indicate that 20 of the cases were "missed." In the absence of a review of these cases by the full panel, which we have essentially adopted as the final scoring device for the random sample, it cannot be stated that all of the missed cases in the control sample are actually injury cases. On the other hand, other results of the study indicate that the reviewers did indeed miss injury cases. Therefore, it can be concluded, although there is considerable risk in assigning quantitative measures, that there are more cases that meet the injury criteria as developed during the study than were detected by the reviewers.

TABLE 9

INITIAL IDENTIFICATION OF INJURIES AMONG CONTROL SAMPLE RECORDS AT PARTICIPATING HOSPITALS

Hospital	Source/Status of Record	Number of Records	Percentage of Records Identified as Injuries
A	Claims		
	Administrator's Case File	10	60%
	Subpoena	10	50
	Incident Report*	11	55
	Total	31	55
B	Claims		
	Subpoena	4	75
	Incident Report*	11	55
	Total	15	60
A & B Combined	Claims		
	Administrator's Case File	10	60
	Subpoena	14	57
	Incident Report*	22	55
	Total	46	57

*Documented evidence by member of medical staff.

It was unfortunate that time constraints prevented the thorough review of all cases in the control sample by the panel during the panel meeting, i.e., those not considered injuries in the initial review, as well as those initially rated as injuries. It is recommended that in future studies all of the control cases be reviewed by a panel of physicians before the records are examined by the medical-legal record checkers.

Results of the Cross-Check Review

As described earlier, the study plan provided for one reviewer to examine 50 records previously examined by the other reviewer. The 50-record sample contained 40 records from the random sample and 10 from the control sample checked by Reviewer A. Further, the sample was structured to contain 25 records that had been initially evaluated as injuries and 25 that had not. Thus, the composition of the sample for the cross-check was:

- 20 random cases judged non-injury
- 20 random cases judged injury
- 5 control cases judged non-injury
- 5 control cases judged injury.

The 50 records constituting the sample were drawn at random from the records in each of the above categories. The 25 injury cases were reviewed by GEOMET's medical-legal consultant to provide assurance that they were indeed representative of the types of injuries encountered. They were judged to be a representative cross-section of the larger random sample. The 50 records were then drawn from the medical record room, and a cover sheet (the GEOMET Medical Record Abstract form [Appendix A]) was prepared for each one, so that it was identical to the sheet presented to the first reviewer. Reviewer B examined the 50 record sample at Hospital A.

For purposes of the cross-check (i.e., to compare the two reviewers on the same set of records), it was not considered necessary to separate the control cases from the random cases. Actually, the results for the random and control samples were essentially identical. The overall results are shown in Table 10. Of the 25 records previously identified as injury cases by Reviewer A, Reviewer B identified 17 injuries; of the 25 not considered injuries by Reviewer A, 3 were classified as injuries by Reviewer B. Thus, the original sample of 25 injuries and 25 non-injuries (Reviewer A) was classified as 20 injuries and 30 non-injuries by Reviewer B. Overall agreement may be estimated by adding the results of the upper left and lower right boxes in Table 10 (bold outline); thus, the reviewers agreed on 39 out of the 50, or 78 percent of the cases, and disagreed on 22 percent of the cases.

TABLE 10

RESULTS OF EXAMINATION OF FIFTY RECORDS BY REVIEWERS A AND B

		Initial Evaluation by Reviewer A		Totals - Reviewer B
		Injury	Non-Injury	
Subsequent Evaluation by Reviewer B	Injury	17	3	20
	Non-Injury	8	22	30
Totals - Reviewer A		25	25	50

REPRESENTATIVENESS OF RANDOM SAMPLE

It was considered important to examine the records constituting the random sample to determine whether or not they were representative of patients in the services sampled. The randomness of the sample was established by means of the method by which the records were drawn (see Section II). Although the possibilities for testing representativeness are numerous, a limited number of tests were performed which indicated that the random sample of records is reasonably representative of the total population of patients discharged by each hospital for the services and time period covered. These are reported below.

Distribution of Sample Records Among Services

The first test of representativeness performed was a comparison of the relative numbers of records from each of the three services sampled with the relative number of patients discharged for each of the three services. This examination, as well as the others reported here, was made possible by the availability of the PAS-MAP summaries covering the period from which the sample was drawn. At the time this analysis was initiated, the first quarterly report for 1972 was available for each hospital. When the second quarterly summary was available at a later date, a comparison indicated that the parameters describing the distribution of patients were stable (i.e., their change from quarter to quarter was negligible). For this reason, the first quarter data were used for comparisons with the three-month sample, although one of the months was outside the first quarter (the sample was drawn from January, March, and May of 1972).

Table 11 shows the distribution of patients in each of the three services for the records drawn in the random sample, and for all patients discharged from the three services during the first quarter of 1972 for Hospitals A and B. In the Hospital A sample, the distribution of sample records among the three services matches the distribution of all discharges among the three services quite closely. A Chi-Square test of the two distributions verified this result at the 0.05 level of significance. The records in the sample represent about 18 percent of all discharges for the period. For Hospital B, the sample distribution does not reflect the distribution of all discharges quite as closely as for the other hospital. The Chi-Square test applied to these data indicated that the distributions were significantly different. The difference is indicated by the relatively small percentage of surgery cases in the random sample. The sample cases represent about 14 percent of all cases in the three services for the period sample.

Comparison of Sample Parameters with Hospital Population

It is also appropriate to compare parameters describing several health care attributes of the sample patients with the same parameters for the total patient population. One example is the average length of stay for patients, by service, as shown in Table 12. The average hospital stay for the patients whose records were drawn in the random sample very closely matches the average stay for all patients discharged during the first quarter of 1972, by service. In Hospital B, the sample tended to include surgical patients

TABLE 11
COMPARISON OF NUMBER OF RECORDS IN THREE-MONTH RANDOM SAMPLE
WITH NUMBER OF DISCHARGES BY SERVICE FOR HOSPITALS A AND B

Service	Hospital A			Hospital B		
	Number of Discharges in Quarter	Random Sample		Discharges in Quarter	Random Sample	
		Number of Records	Percent of Discharges		Number of Records	Percent of Discharges
Medicine	735	136	19	916	153	17
Surgery	944	166	17	1571	183	12
Gynecology	425	89	20	242	48	20
Total	2104	391*	18**	2729	384*	14**

*Does not include cases with discharge dates outside three-month sample period; this accounts for discrepancy between this total and size of random sample.
**Overall percentage.

with an average stay somewhat longer than the average for all surgical patients discharged from that hospital during the first quarter of 1972.

TABLE 12
COMPARISON OF AVERAGE HOSPITAL STAY (DAYS) FOR PATIENTS DISCHARGED DURING FIRST QUARTER 1972 WITH PATIENTS IN RANDOM SAMPLE BY SERVICE FOR HOSPITALS A AND B

Service	Hospital A		Hospital B	
	Random Sample	All Patients	Random Sample	All Patients
Medicine	8.1	8.3	8.0	8.0
Surgery	7.8	7.4	8.9	7.3
Gynecology	4.5	4.3	5.3	5.2
Overall Averages	7.2	7.1*	8.1	7.3*

*Only includes services shown, i.e., Pediatrics not included.

Another test is the comparison of the distribution of ages of patients in the random sample with the age distribution for all patients at each hospital. It can be seen in Tables 13 and 14 that the age distribution of the patients whose records were drawn in the sample matches fairly closely the distribution for all patients discharged during the quarter. The observed differences tend to be where the number of cases is small, thus reducing the significance of the difference. In both hospitals, the highest median patient age is associated with the medical service, the lowest with gynecology. For each service, the Hospital B median patient age is greater than for Hospital A.

Table 15, showing the results of a comparison of the total random sample of medical records with patient age data for discharges from all PAS-MAP hospitals, indicates that the sample had a relatively higher fraction of patients over 65 years of age. Because pediatric patients were excluded from the sample, only data for patients over 20 were examined.

COMPARISON OF INJURY PARAMETERS WITH SAMPLE

One of the issues addressed in the analysis involved a comparison of the distribution of key parameters associated with the patients judged to have been injured with the distribution of the same parameters among the patients in the random sample.

Distribution By Service

First, the distribution of injury cases among the three services was compared with the distribution of the total sample. Note that the injury cases summarized are from discharges drawn for January, March, and May of 1972. The number of injury cases in each hospital is somewhat small for a sophisticated statistical analysis, but the distribution of injury patients over the three services does not strictly match the sample distribution for Hospital A, although the distribution for Hospital B is similar. In

TABLE 13
COMPARISON OF AGE DISTRIBUTION BY SERVICE AT HOSPITAL A FOR PATIENTS DISCHARGED DURING FIRST QUARTER 1972 WITH PATIENTS IN THREE-MONTH RANDOM SAMPLE

Patient Age (Years)	Surgery				Medicine				Gynecology			
	First Quarter Discharges		Three-Month Random Sample		First Quarter Discharges		Three-Month Random Sample		First Quarter Discharges		Three-Month Random Sample	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-19	172	18%	10	6%	15	2%	5	4%	37	9%	6	7%
20-34	167	18	38	23	71	10	16	12	248	58	52	59
35-49	188	20	38	23	111	15	21	15	106	25	18	20
50-64	196	21	36	22	202	27	40	29	25	6	11	12
65+	221	23	44	26	336	46	54	40	9	2	2	2
Total	944	100%	166	100%	735	100%	136	100%	425	100%	89	100%

TABLE 14
COMPARISON OF AGE DISTRIBUTION BY SERVICE AT HOSPITAL B FOR PATIENTS DISCHARGED DURING FIRST QUARTER 1972 WITH PATIENTS IN THREE-MONTH RANDOM SAMPLE

Patient Age (Years)	Surgery				Medicine				Gynecology			
	First-Quarter Discharges		Three-Month Random Sample		First Quarter Discharges		Three-Month Random Sample		First Quarter Discharges		Three Month Random Sample	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-19	89	6%	2	1%	9	1%	1	1%	14	6%	1	2%
20-34	216	14	30	16	76	8	11	7	88	36	22	46
35-49	260	16	34	19	111	12	19	12	94	39	20	42
50-64	358	23	46	25	174	19	32	21	30	12	3	6
65+	648	41	71	39	546	60	90	59	16	7	2	4
Total	1571	100%	183	100%	916	100%	153	100%	242	100%	48	100%

particular, the number of injuries among the patients in medicine in Hospital A is relatively small compared to the fraction of patients in the sample from that service, while the injuries in surgery and gynecology are at higher rates than would be expected from their proportions in the random sample. When the data from both hospitals are combined, the Chi-Square test indicates that the differences in the distributions are not significant at the 5 percent level. The results are confirmed by Table 16, where the injury rates are shown for each service. The Hospital A medicine injury rate is only 1.5 percent, in accordance with the results noted above. The overall results show that the injury rate is highest for surgery patients.

TABLE 15
COMPARISON OF RELATIVE DISTRIBUTION OF PATIENT AGE IN THREE-MONTH RANDOM SAMPLE WITH ALL PAS-MAP HOSPITALS*

Patient Age (Years)	All PAS-MAP Hospitals	Random Sample
20-34	20%	20%
35-49	25%	20%
50-64	27%	22%
65+	28%	38%

*Patients over 20 years.

Age Distribution

In examining the age distribution among the injured patients, the numbers were considered too small to break them down by service. Table 17 summarizes the injury rates for different patient age groups. The results indicate a 14 percent injury rate at Hospital B among patients 65 and older. Although this group constituted 42 percent of the sample patients, 66 percent of the injuries were in this age group. Also of note is the 10 percent injury rate among patients 35 to 49 at Hospital A. Tests indicate that the age distribution of injured patients and all patients in the sample are not statistically different for each hospital. It is not clear whether age or service is the principal factor associated with injury. It has been noted, however, that the oldest patients are associated with medicine services, and that the highest injury rate in the Hospital B random sample was among surgery patients.

Length of Stay

The comparison of average length of stay for injured patients with all patients in the sample is shown in Table 18. The results show that injured patients in surgery and gynecology have significantly longer stays than the average patient in the sample; in fact, the stay is about twice as long. This is not true for patients in medicine. Since only two injury cases were reported for medicine at Hospital A, the sample was considered too small for statistically reliable results. Five of the 14 injuries in medicine at Hospital B were deaths. Thus, these results suggest a strong association between over-average hospital stays and injury, except where death terminated the hospital stay. "Association" here does not necessarily imply a cause-and-effect relationship. The longer hospital stay of an injured patient may be due to the additional therapy required to treat the injury,

TABLE 16

INJURY RATES BY SERVICE: THREE-MONTH RANDOM SAMPLE AT HOSPITALS A AND B

Service	Hospital A		Hospital B		Injury Rate Both Hospitals Combined (%)
	Number of Records Three-Month Sample	Injury Rate (%)	Number of Records Three-Month Sample	Injury Rate (%)	
Medicine	136	1.5	153	9.4	6
Surgery	166	7.8	183	10.4	9
Gynecology	89	7.5	48	4.2	7

as opposed to indicating that the injury occurs because the patient is hospitalized longer. The length of stay is also clearly related to the cause of the original hospitalization, which may be the controlling factor.

DATA PROJECTIONS

In order to provide another view of the implications of this study, limited projections from the available data have been made. Although it would appear desirable to provide these projections on as wide a base as possible, statistical limitations make such projections somewhat hazardous. As a compromise, this section gives estimates of the total number of injuries, cases of negligence, and claims that can be expected in both hospitals, associated with patients discharged during 1972.

The number of discharges in 1972 can be stated with reasonable confidence using quarterly figures which appear relatively stable. The total number of discharges from both hospitals is estimated to be approximately 19,000 patients, considering only surgery, medicine, and gynecology patients. The overall final injury rate obtained in the study was 7.5 percent. Although the conduct of the study was such that this rate must be considered low, it can be used as the basis for conservatively estimating that the number of injuries among patients discharged during the year approximates 1,425 cases.

Based on the negligence cases cited above, a "negligence rate" (i.e., the percentage of injuries presumably caused by negligence) can be predicted for the two sample hospitals. The study identified 18 negligence cases among the 62 injuries for a negligence rate of 29 percent. Using this figure in conjunction with the 1972 estimate of injuries, the total estimated number of negligence cases for 1972 would be 413. This procedure, however, must be considered rather tenuous for two reasons: (1) the quantity of data on which the estimate is based is small in the statistical sense, and (2) the reviewers themselves were not highly confident in their rating of the cases in which the injuries were ascribed to negligence.

Data were obtained from each hospital giving the number of claims made against the hospital or medical staff each year, and the year of patient discharge associated with each claim. By means of a regression analysis, the number of claims arising for each year from 1960 to 1971 were used to estimate the total number of claims to be expected from patients discharged during 1972. The estimated number is approximately 31. Since all of the data examined in the study are associated with patients accounting for 80 percent of discharges from the two sample hospitals, this estimate can be adjusted to be compatible with the other results in this section, yielding an estimate of 25 claims.

Estimates of the injury results predicted for medicine, surgery, and gynecology patients discharged from both hospitals (combined) during 1972 are:

- 19,000 patients
- 1,425 injuries
- 413 negligence cases
- 25 claims.

Since the services sampled for this study account for approximately 80 percent of all discharges, these results can be extended to all discharges, if it is assumed that the injury and negligence rates obtained also apply to the services that were not sampled. These estimates for total patients, injuries, negligence cases, and claims are:

- 23,750 patients
- 1,780 injuries
- 517 negligence cases
- 31 claims.

Section IV
Findings and Conclusions

The methods used in this study successfully supported a study of patient injuries in the hospital setting; they included the selection of medical records on a random basis, initial examination of the records by medical-legal

TABLE 17
INJURY RATES BY PATIENT AGE GROUP: THREE-MONTH RANDOM SAMPLE FOR HOSPITALS A AND B

Patient Age (Years)	Hospital A		Hospital B		Injury Rate Both Hospitals Combined (%)
	Number in Random Sample	Injury Rate (%)	Number in Random Sample	Injury Rate (%)	
0-19	21	0	4	0	0
20-34	106	5	63	5	5
35-49	77	10	73	4	8
50-64	87	5	81	6	5
65+	100	5	163	14	11

TABLE 18
COMPARISON OF AVERAGE LENGTH OF STAY (DAYS) BY SERVICE FOR INJURED PATIENTS AND RANDOM SAMPLE FOR HOSPITALS A AND B

Service	Hospital A		Hospital B	
	Three-Month Random Sample	Injured Patients	Three-Month Random Sample	Injured Patients
Medicine	8.1	6.5	8.0	9.4
Surgery	7.8	18.7	8.9	14.4
Gynecology	4.5	10.3	5.3	12.0
Overall	7.2	15.0	8.1	12.2

experts, and subsequent review by a medical panel. The techniques modified on the basis of the experience gained in this study can be applied on a wider scale in the future.

The following findings and conclusions are drawn from the results presented in the preceding sections of the report:

- On the basis of a review of a random sample of medical records drawn from medical, surgical, and gynecological services at two general hospitals, it has been found that 7.5 percent of the records show evidence of iatrogenic injury. *Several factors indicate that this number significantly underestimates the true rate.*
- Review of medical records by medical-legal experts is feasible; an average rate of 50 records per day can be achieved, but probably not on a sustained basis.
- Several possibilities exist for screening records to increase the probability of identifying injuries in the sample; these include seeking records for patients with over-average hospital stays.

Section V
Recommendations for Future Work

On the basis of the results achieved in this preliminary study, it is recommended that additional work of the same type be conducted on a national scale. This study should be structured in such a way as to develop reasonably reliable statistics on a national basis. The scheme should be set up so that a representative sample of hospitals is covered. This sample should be structured to be representative in geographical location, control, approvals, and facilities.

The present study provided some indication that criteria exist by which records can be pre-selected to increase the likelihood of finding injury cases in the sample, as opposed to a purely random sample. Specifically, it would appear that hospital stays longer than age- and diagnosis-corrected norms, as well as cases of death in the hospital, may be useful criteria for this purpose. At present, however, such a sample would not allow extrapolation to the general hospital population. Therefore, it is recommended that an initial large-scale study be based on a set of records chosen at random, essentially as was done in the present study. With a reasonably large sample collected on a national basis, reliable statistical relationships can be developed to relate the number of cases found in a biased sample to those found in the random sample. With this information, continuing efforts to monitor the incidence of injuries could then be based on reviews of smaller samples of records, selected on the basis of specific criteria.

The forms (Appendix A) developed for this study could be used in the future with only slight modification. They should be reviewed for purposes of simplifying the transfer of data to digital computer storage. It may be worthwhile in larger studies to consider selecting the sample prior to the time that the PAS-MAP abstract forms are completed, so that duplicates of these forms may be attached to the other data forms used in the study. This would conveniently make available an abstract of the medical record for statistical analysis of the patient data.

It is recommended that close supervision of the record reviewers be maintained during the conduct of the record review. This is not required throughout the entire period of the review, but the information that is desired for the actual cases judged to be injuries should be checked. That is, at periodic intervals during the record review process, those forms completed for the cases identified as injuries should be examined for completeness.

The information developed in successive studies of this type, including a continuous monitoring process, could be designed so as to relate to various other on-going hospital information systems such as the *Illinois Hospital Admission Surveillance Program* (HASP) for reviewing hospital admissions. Further detailed studies, not possible within the scope of the present effort, should be devoted to relating the injury information for each hospital to its own efforts to ensure quality of care. Efforts should be devoted to relating the criteria discussed above for selecting records for injury examination with criteria used to select records in other hospital admission and utilization review systems.

The injury data that could be obtained from on-going programs of medical chart review could be processed most conveniently by a computerized system. It is recommended that consideration be given to developing an information system that would contain the injury data updated on a continuing basis. This would provide the output needed for overall review of the quality of care provided by each hospital; it would also provide a significant input to the analysis of need for changes in policy relative to malpractice claims.

Steps outlined here that detail how to determine hospital injury rates, combined with quality assurance methods instituted by a hospital, may reduce the incidence of patient injury, and thus constitute a significant measure in reducing the entire malpractice problem, at its source.

Section VI
References

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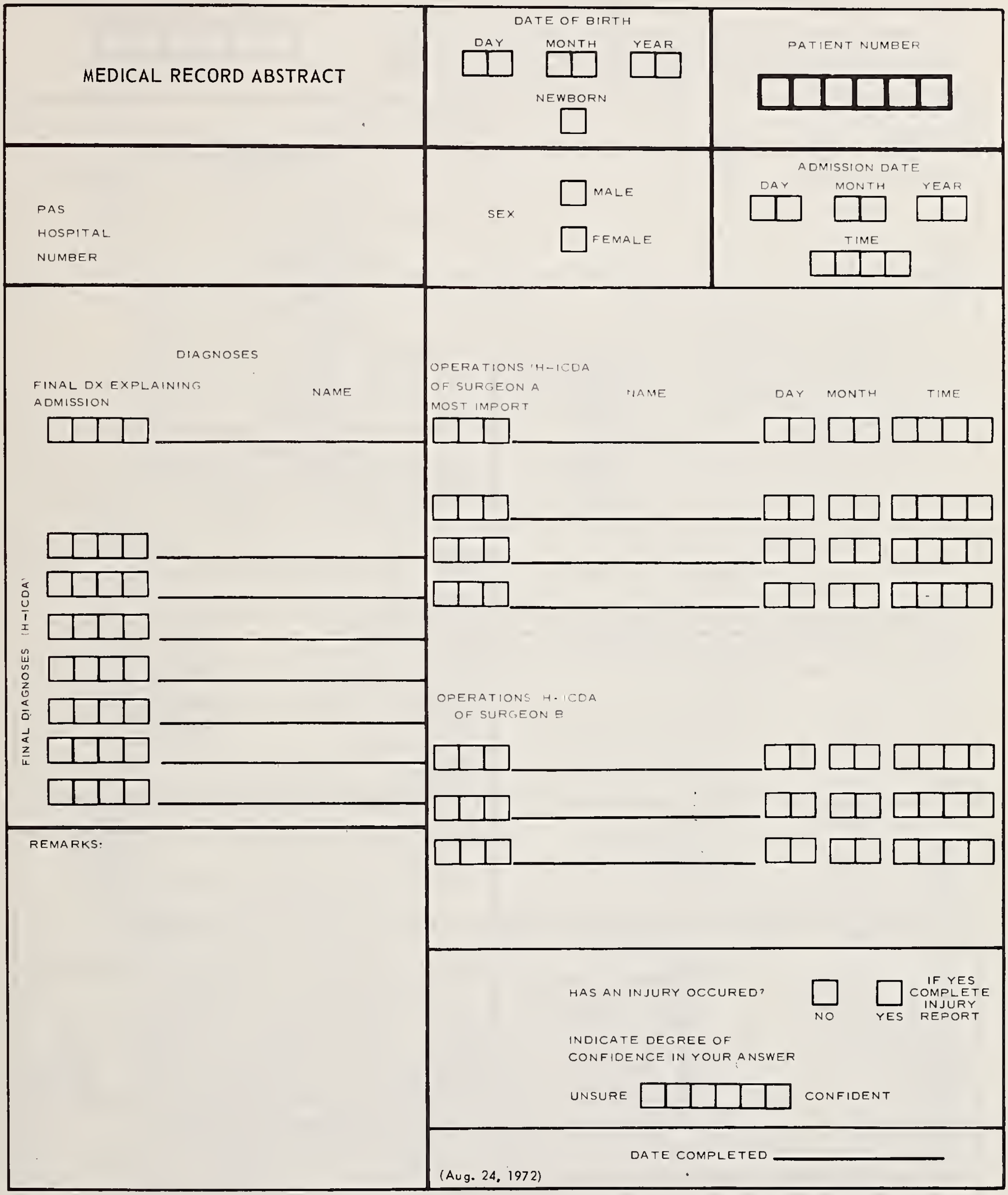
Appendix A
DATA FORMS



MEDICAL RECORD ABSTRACT

DATE OF BIRTH
DAY ☐☐ MONTH ☐☐ YEAR ☐☐
NEWBORN ☐

PATIENT NUMBER ☐☐☐☐☐☐

PAS
HOSPITAL
NUMBER

SEX ☐ MALE ☐ FEMALE

ADMISSION DATE
DAY ☐☐ MONTH ☐☐ YEAR ☐☐
TIME ☐☐☐☐

DIAGNOSES

FINAL DX EXPLAINING ADMISSION	NAME
☐☐☐☐	______

FINAL DIAGNOSES (H-ICDA)

☐☐☐☐	______
☐☐☐☐	______
☐☐☐☐	______
☐☐☐☐	______
☐☐☐☐	______
☐☐☐☐	______
☐☐☐☐	______

REMARKS:

OPERATIONS (H-ICDA) OF SURGEON A MOST IMPORT	NAME	DAY	MONTH	TIME
☐☐☐	______	☐☐	☐☐	☐☐☐☐
☐☐☐	______	☐☐	☐☐	☐☐☐☐
☐☐☐	______	☐☐	☐☐	☐☐☐☐
☐☐☐	______	☐☐	☐☐	☐☐☐☐

OPERATIONS (H-ICDA) OF SURGEON B				
☐☐☐	______	☐☐	☐☐	☐☐☐☐
☐☐☐	______	☐☐	☐☐	☐☐☐☐
☐☐☐	______	☐☐	☐☐	☐☐☐☐

HAS AN INJURY OCCURED? ☐ NO ☐ YES IF YES COMPLETE INJURY REPORT

INDICATE DEGREE OF CONFIDENCE IN YOUR ANSWER

UNSURE ☐☐☐☐☐☐ CONFIDENT

DATE COMPLETED ______

(Aug. 24, 1972)

DATA FORMS (Continued)

INJURY REPORT

Patient No. ☐☐☐☐☐☐

Describe Injury: ______________________________

____

____

Time of Occurrence

☐ Before ☐ During ☐ After

Hospitalization

☐ During a Procedure

☐ Subsequent to and related to a Procedure

What Procedure: ____________

Is there an entry on record indicating recognition of injury? ☐ YES ☐ NO

If so, was there a delay in its discovery? ☐ YES ☐ NO

If so, how long? ____________

What was effect of delay? ____________

____

Evidence of Injury (Number in order of decreasing significance: 1 most significant)

☐ Lab. Report

☐ X–Ray Report

☐ Path. Report

☐ Op. Results from Surgery

☐ Autopsy

☐ Consultation Reports

☐ Nurses Notes

☐ Admitting Work–up

☐ Anesthetic Charts

☐ Vital Sign Charts

☐ Progress Notes

☐ Other ____________

Source of Injury

☐ Attending M.D.

☐ House M.D. staff

☐ Consultant M.D.

☐ Nurse

☐ Aide

☐ Pharmacist

☐ Other ____________

☐ Radiologist

☐ Radiology tech.

☐ Anesthesiologist

☐ Anesthetist

☐ Pathologist

☐ Laboratory tech.

☐ Unknown

Date Form Completed ____________

Severity of Injury

1 ☐ Mental Injury Only

Temporary
- 2 ☐ Insignificant
- 3 ☐ Minor
- 4 ☐ Major

Permanent
- 5 ☐ Minor
- 6 ☐ Significant
- 7 ☐ Major
- 8 ☐ Grave

9 ☐ Death

Delay in Recovery? ☐ Yes ☐ No

Check one or more of following factors associated with case:

☐ Abandonment

☐ Clinical Research

☐ Failure to Disclose

☐ Consent

☐ Defamation

☐ Other ____________

☐ Products Liability

☐ Prenatal Injury

☐ Laboratory Error

☐ Diagnosis Error

☐ Pharmacy Error

Did negligence cause the injury? ☐ YES ☐ NO

Indicate degree of confidence in response

UNSURE ☐☐☐☐☐☐ CONFIDENT

Prediction of outcome of legal action:

☐ FOR PLAINTIFF ☐ ☐ UNSURE ☐ ☐ FOR DEFENSE

Additional Notes Prepared In this Case?

☐ YES ☐ NO

If YES show Patient Number on all Continuation Sheets.

(Aug. 24, 1972)

Appendix B

BASIC PATIENT INJURY DATA

Hospital A

Age	Sex	H-ICDA	Diagnosis	Confidence that an Injury Occurred	Evidence of Injury	Source of Injury	Severity of Injury	Description of Injury	Did Negligence Cause the Injury?	Confidence in Answer	Predicted Legal Outcome
31	F	733.5	Dupuytren's Contracture, Foot					Postoperative Infection/Hematoma		5	4
44	F	189.0 998.9	Adenocarcinoma, Kidney Pneumonitis		4	1	5	Neoplasms/Diagnostic Error Pneumonitis		5	4
38	M	724.4 998.9	Knee Surgery Pulmonary Embolism	3	2		4	Pulmonary Embolism		6	5
61	M	550.0 998.9	Recurrent Inguinal Hernia Septic Thrombophlebitis		11		3	Postoperative Thrombophlebitis		6	5
45	F	708.9	Urticaria, Drug-Induced		12	1	4	Antibiotics/Adverse Effects	Y		
78		440.9 814.0	Arteriosclerosis Fracture, Wrist	6	11	4	4	Slip and Fall/Wrist Injury	Y	4	2
32	F	623.6	Uterine Prolapse		10		4	Hysterectomy/Infection	Y	6	2
22	F	616.0	Abscess, Pelvic	6		1	4	Tubal Ligation/Infection	Y	4	2
32	F	998.5	Wound Infection, Surgical	6	10	1	3	Hysterectomy/Infection	Y	5	5
24	F	599.9	Urinary Tract Infection	6	1		3	Hysterectomy/Infection		6	5
66	F	996.6	Osteomyelitis, Tibia	6	2		6	Fracture Fixation/Infection	Y	4	5
	F	623.6	Uterine Prolapse	6				Hysterectomy/Infection	Y		
35	M	998.5	Intra-abdominal Abscess	6			4	Colostomy/Infection	Y	3	3
78	F	562.1	Diverticulitis	6	11		4	Colectomy/Infection/Dehiscence		6	5
63	F	725.1	Intervertebral Disc	6	7		3	Slip and Fall/Thoracic Injury		5	4
53	F	820.0	Fracture, Hip	6	10		3	Fracture Fixation/Infection		5	5
26	M	455.0 595.0	Hemorrhoids Cystitis	6	11	5	3	Catheterization/Infection		5	5
69	M	600.0	Prostatic Hypertrophy				3	Prostatectomy/Infection		6	5
37	F	640.0 867.0	Abortion, Complete Uterine Perforation	6	4	1	3	Uterine Perforation			3

(Continued)

BASIC PATIENT INJURY DATA (Continued)

Hospital A (Concluded)

Age	Sex	H-ICDA	Diagnosis	Confidence that an Injury Occurred	Evidence of Injury	Source of Injury	Severity of Injury	Description of Injury	Did Negligence Cause the Injury?	Confidence in Answer	Predicted Legal Outcome
45	F	623.4	Uterine Prolapse	6	10		3	Hysterectomy/Infection		5	5
	M	455.0	Hemorrhoids	6	11	1	4	Hemorrhoidectomy/Complications		5	5
39	F	623.0 620.0	Cystocele Pelvic Infection	6	1	1	3	Hysterectomy/Infection		4	5
39	M	532.1 998.5	Duodenal Ulcer/Hemorrhage Wound Infection	6	11		3	Pyloroplasty/Infection		6	5
89	F	410.9 873.0	Myocardial Infarct Laceration, Scalp	6	11		3	Slip and Fall		4	4
66	M	410.0	Myocardial Infarct	6	11		4	Prostatectomy/Cardiac Arrest/ Infection	Y	6	4
28	F	626.6	Menorrhagia	6	4	1		Uterine Perforation	Y	6	5
84	M	820.0	Fracture, Hip				4	Fracture Fixation/Complications		5	4

BASIC PATIENT INJURY DATA (Continued)

Hospital B

Age	Sex	H-ICDA	Diagnosis	Confidence that an Injury Occurred	Evidence of Injury	Source of Injury	Severity of Injury	Description of Injury	Did Negligence Cause the Injury?	Confidence in Answer	Predicted Legal Outcome
65	M	436.0 251.0	Cerebral Thrombosis Hypoglycemia, Drug-Induced	4	1		3	Drug Therapy/Adverse Effects		3	3
88	F	574.9 427.2	Cholecystitis Cardiac Arrest	6	4	1	9	Cholecystectomy/Cardiac Arrest	Y	3	2
62	M	682.1 787.3	Abscess, Hip Stress Ulcer/Hemorrhage	6	10	1	9	Infection/Hemorrhage	Y	2	2
75	M	451.0	Thrombophlebitis	6	8	1	3	Prostatectomy/Thrombophlebitis		5	5
65	M	713.0	Arthritis, Hip	6	9	10	4	Anesthesia/Aspiration	Y	1	3
69	F	198.0 450.0	Carcinoma, Breast Thrombophlebitis	6	11	1	9	Pulmonary Embolism/Therapy	Y	1	3
81	F	433.1 788.7	Cerebral Thrombosis Hyponatremia	6	1	4	9	Hyponatremia/Fluid Therapy	Y	5	1
41	F	635.0	Hemorrhage/Gastrointestinal	6	12	7	4	Blood Transfusion/Adverse Effects		5	4
41	F	626.6	Menorrhagia	3	10	14	3	Hysterectomy/Infection/Shock Penicillin/Adverse Effects		3	4
85	M	600.0 450.0	Coronary Artery Disease Pulmonary Embolism	6	10	4	9	Prostatectomy/Aspiration	Y	4	2
60	M	450.0	Pulmonary Embolism	6	2	1	3	Hip Surgery/Pulmonary Embolism		3	4
70	F	531.0 873.0 887.0	Gastric Ulcer Liver Degeneration Laceration, Scalp	6	7	4	3	Slip and Fall	Y	4	1
71	F	207.1	Lukemia	6	1	1	4	Drug Therapy/Adverse Effects		3	4
75	M	998.1	Prostatectomy/Hemorrhage	6	8	1	3	Prostatectomy/Hemorrhage		5	5
85	F	820.0	Fracture, Femur	4				Hip Surgery/Thrombophlebitis		4	4
24	M	590.2	Renal Abscess	6	1	7	4	Tooth Extraction/Complications		1	3
82	F	154.1 813.4 820.2	Carcinoma, Rectum Fracture, Wrist Fracture, Femur	6	2	4	4	Slip and Fall		1	3

(Continued)

BASIC PATIENT INJURY DATA (Continued)

Hospital B (Concluded)

Age	Sex	H-ICDA	Diagnosis	Confidence that an Injury Occurred	Evidence of Injury	Source of Injury	Severity of Injury	Description of Injury	Did Negligence Cause the Injury?	Confidence in Answer	Predicted Legal Outcome
64	F	712.3 531.0 255.9	Rheumatoid Arthritis Peptic Ulcer Adrenal Insufficiency	6	8	1	7	Drug Therapy/Adverse Effects			3
69	M	441.3	False Aneurysm	3	8	1	4	Vascular Surgery/Complications		4	4
72	F	783.0	Epistaxis, Drug-Induced	6	6	1	6	Anticoagulants/Adverse Effects		3	4
45	F	232.2	Cyst, Buttock	3	3	4	3	Injection/Complications		2	4
40	M	357.9	Radiculitis	6	4	1	3	Spine Surgery/Complications			3
69	F	401.0	Hypertension	3	1		4	Aortography/Complications			
71	F	996.6	Wound Infection	6	1	1	3	Fracture Fixation/Infection			3
80	M	173.6 436.0	Lymphoma, Buttock Cerebral Thrombosis	6	7	1	9	Wound Dehiscence/Infection Cerebral Thrombosis		1	3
77	M	551.3	Diaphragmatic Hernia	4	2	1	3	Herniorrhaphy/Complications Esophageal Stricture		4	4
66	M	600.0 450.0	Prostatic Hypertrophy Pulmonary Embolism	6	6	1	3	Prostatectomy/Pulmonary Embolism		6	5
82	M	250.0 390.1	Diabetes Mellitis Cellulitis, Arm	6	1	2	9	Infection/Complications Diabetes Mellitus/Therapy	Y	5	1
74	M	600.0	Prostatic Hypertrophy	5	12	1	4	Prostatectomy/Complications			3
27	F	551.1	Umbilical Hernia	6	4	1	3	Herniorrhaphy/Suture Infection		3	4
69	F	486.0	Pneumonia	6	10	1	9	Pneumonia/Therapy	Y	1	2
69	M	600.0	Prostatic Hypertrophy	5	4	1	3	Prostatectomy/Complications		3	4
29	F	626.9 622.1	Menorrhagia Pelvic Abscess/Hematoma	6	1	1	4	Hysterectomy/Hemorrhage/ Infection		4	4
63	F	427.3 429.0	Arteriosclerosis Cardiac Arrest	6	7	3	3	Pacemaker/Complications		3	4
63	M	574.9 792.0	Cholecystitis Azotemia	6	1	1	3	Tetracycline/Adverse Effects		2	4

MEDICARE AND MALPRACTICE

Evelyn J. Bradford, J.D.

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This paper is intended to present briefly the relevant findings of a study exploring the relationship between the Medicare program and malpractice. Because of the twofold nature of the Medicare program (Part A, institutional care and Part B, physicians' services) and the limitations of time and resources to undertake the study, this report will focus entirely on Part A. While it will not attempt to cover every aspect of the subject in complete detail, it will attempt to pinpoint the nature and development of the major difficulties and their relationship to the malpractice problem.

Why a Study of Medicare

Under its charter, the Commission has been directed to explore all aspects of the malpractice phenomenon, including its relationship to and impact on direct Federal and Federally-supported health care programs. If the rising number of malpractice claims are in fact causing health care costs to rise, there is little doubt that Federal health care programs such as the Medicare program are paying a significant part of these additional costs. By the same token, if the rising number of claims are indicative of a breakdown in health care standards and/or quality control mechanisms, then these consequences surely must be reflected in the Medicare program.

The magnitude of the Medicare operation makes these possible consequences most significant. As compiled by the Office of Research and Statistics, Division of Health Insurance Studies, SSA, approximately 8.6 million Part A health insurance claims were processed during FY 1971, representing a total expenditure of about five and one half billion dollars for this one period.

Given the fact that a substantial portion of all the health care provided in this country is paid for by the Federal Government under the Medicare program, the necessity to measure and evaluate the relationship and impact of the malpractice environment and the operation of the Medicare program on each other is self-evident. Given the further fact that the relationship between the provider and the patient is of paramount importance in the creation of a climate that can either aggravate or diminish the development of malpractice litigation, it becomes equally necessary to examine the effect of the Medicare program on this relationship. Specifically: What happens to the "rapport" between the provider and the patient when the provider suddenly informs the patient months after the hospital

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services have been rendered that Medicare has disallowed his claim and that there is now a sizeable bill that must be promptly paid? What good feeling can exist between a provider and a patient when payment for care for a dying person in an extended care facility is denied by the Government on the seemingly spurious ground that no "skilled nursing services" were necessary for the fatal condition?

According to a number of experts in the health care field, the aggrieved patient is the most likely malpractice litigant, whether his complaint stems from medical failure or financial harassment. There is, apparently, a frustration level that patients reach in their encounters with the health care system, beyond which their tolerance and cooperation cease to function. When this provider-patient breakdown occurs, malpractice suits are more likely to flourish.

Translated into practical Medicare terms, we have a Medicare beneficiary who is entitled to benefits but who finds out a few months after leaving the hospital and/or extended care facility that the Government will not pay his bill because his care was not covered. Inevitably, such a disallowance inspires anger and recrimination: the hospital is blamed for not having told him when he was there; the doctor is blamed for having sent him in the first place when he should have known better! Multiply this by a few hundred thousand beneficiaries each year and there is indeed a potential national health-care catastrophe.

Unfortunately, there has been no pertinent research in or out of the Department of Health, Education and Welfare which has quantified the exact number of malpractice cases which have stemmed from Medicare denial or dysfunction. That general increasing dissatisfaction with the Medicare program exists, however, is beyond dispute. Recent articles in the medical press, for instance, label the entire extended care facility operation under Medicare a "hoax." One in particular, entitled "Guess Who's Losing These Doctor vs Medicare Games,"[1] says of the Government health insurance program: "Our adversary [Medicare] makes arbitrary and sometimes secret rules. . . . What happens to the doctor-patient relationship when these games are played out to the point of a retroactive claim denial? When the patient is told that the condition isn't covered by Medicare, I can imagine him musing along these lines: "But I was very sick when I went to the hospital. Why did my doctor call my illness something that wasn't covered? He can't be very smart. I wonder how good a doctor he really is."[2]

Consumer disgruntlement, similarly, is readily apparent. Formal requests for reconsideration of disallowance determinations are steadily growing in number (38,000 for 1971, of which about 18 percent were reversed and paid, and 82 percent affirmed); requests for more advanced adminstrative processes are also increasing (6,158 claimants requested hearings and 3,716 claimants requested Appeals Council review after hearings; and seventy-nine claimants went on to seek court action in the past year, despite the fact that the jurisdictional boundaries in all of these procedures is limited by the statute). In addition, a steady stream of mostly unhappy letters (at least 18,000 per year) flows into the offices of the Health Inquiries Branch of the Bureau of Health Insurance, representing inquiries and complaints from Congressmen (whose constituents have written to them), from doctors, from beneficiaries, and from families and friends of beneficiaries. Nor is any count taken at all of the thousands of aggrieved beneficiaries who, on the lowest level, present their cases unofficially and in vain to the local district offices but are unable or afraid to pursue further administrative remedies.

It must be accepted, accordingly, that the manner in which Medicare claims are being handled is apparently fostering a climate for health care delivery that is fertile soil for the growth of malpractice litigation. There is usually only anger and bitterness that a Medicare beneficiary feels when he discovers, during or after the fact, that a hospital or nursing home bill he had believed would be paid by the Government has been disallowed.

Disallowances of bills, therefore, and denial of payment under Medicare, are currently among the most disruptive forces undermining the provider-patient relationship in the medical field. Disallowances result in dissatisfied patients. Dissatisfied patients can easily become vindictive people, and vindictive people are more likely to be the plaintiffs in malpractice lawsuits.

Logically, then, the entire Medicare denial syndrome must be carefully examined in the light of its impact on the malpractice phenomenon. How are denials determined? Is the methodology equitable? Is it uniformly enforced throughout the United States? Is there ample provision for administrative and judicial review? In short: why do so many Medicare beneficiaries feel they are victimized by the Government and the providers in the Medicare program; and what can be done to improve the relationship among those concerned?

The Medicare Program

The 1965 Amendment to the Social Security Act (P.L. 89-99, 79 Stat. 286) added to that Act a new Title XVIII establishing the program of health insurance for the aged, popularly known as Medicare. The program consists of 2 parts.

Part A of Title XVIII establishes a program of hospital insurance benefits for the aged to be financed from a trust fund composed of deposits from certain taxes on wages and self-employment (Section 1817 42 USC 1395 i). Under this part, persons entitled to retirement benefits under Title II of the Social Security Act or under the Railroad Retirement Act are entitled to receive a certain number of days of care in hospitals and in extended care facilities subject to the payment of a hospital deductible and certain coinsurance. They also are entitled to receive a specified number of visits for post-hospital home health services

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[1] Philip R. Alper, M.D., "Guess Who's Losing These Doctor vs. Medicare Games," *Medical Economics,* October 23, 1972, pp. 88-95.

[2] 397 U.S. 254, 1970

(Sections 1812 (d), 1861 (m) and (n) 42 USC 1395 (d), 1395 X (m) and (n)). These services must have a medical orientation as per the statute, and section 1862 (a) (9) 42 USC 1395y (a) (9) specifically prohibits reimbursement for services for "custodial care."

Part B of Title XVIII establishes a program of supplementary medical insurance for the aged, which provides protection against a substantial part of the costs of physicians' services and a number of other health items and services not covered under the hospital insurance program. Its provisions apply, with minor exception, to any individual who has attained age 65 and who voluntarily enrolls in the Part B program. It is funded from a separate trust fund financed by the premium of beneficiaries and matching government contributions. Both Parts A and B of the Medicare program are administered by the Social Security Administration of the United States Department of Health, Education and Welfare.

The Part A Medicare Statutory Structure

Under the Act, the term "provider of services" means a hospital, extended care facility or home health agency (Section 1861 (u), 42 USC 1395 (u). A provider of services is qualified to participate in the Medicare program if it files with the Secretary in agreement assuring compliance with the fiscal, accounting, administrative, and coverage provisions of Part A (Section 1866, 42 USC 1395 cc).

Congress provided for the processing of claims for reimbursement under the Medicare program by agencies such as Blue Cross Associations and commercial insurance companies acting on behalf of the Government (Sections 1816 and 1842 of the Social Security Act; 42 USC 1395h and 1395u):

> "In the performance of their contractual undertakings, the. . . . fiscal intermediaries would act on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the bill. The Secretary, however, would be the real party in interest in the administration of the program, and the Government would be expected to safeguard the interests of his contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secretary." Senate Report 404, 89th Congress, 1st Session, page 54.

Accordingly, the Secretary has entered into agreements with the Blue Cross Associations and other commercial insurance companies to serve as "intermediaries" for the purpose, among other things, of making initial determinations of the circumstances under which providers of services would be paid for services provided to individuals.

It is each provider of services who nominates an intermediary to act in such capacity for him, subject to Government approval, of course, unless the provider chooses to deal directly with the Government through the Direct Reimbursement Branch of the Bureau of Health Insurance. Each provider must enter into a contract of participation with the Government; and each intermediary must sign a separate Part A agreement with the Government on its own. General, overall responsibilities for the intermediary are spelled out in the Part A agreements. More specific instructions are set forth in the Manual and the Intermediary Letters.

Since the Medicare program, by law, specifically excludes from payment certain services furnished, the intermediary's primary function under its contract with the Secretary is to make the initial judgments as to whether the services rendered in each particular case fall within the scope of services covered by the statute. For example, section 1862 (a) (1) of the Social Security Act 42 USC 1395y (a) (1) prohibits reimbursement under the Medicare program for items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; section 1862 (a) (9) excludes from payment all care which is "custodial." Thus, where an intermediary determines that the services in a given situation are beyond the coverage delineated in the statute, it terminates reimbursement for such services and informs the provider and the beneficiary of its denial.

Where a beneficiary is dissatisfied with an intermediary's negative decision in his case, he can pursue further administrative and legal action provided for his benefit by law. Under Part A, a beneficiary's first step following a denial by an intermediary is to file a "Request for Reconsideration." Upon receipt of the request, the claim is reviewed by the intermediary, based on the record, including any enlargements thereof by the intermediary or the claimant (Claims Manual 3783.3), and then the record is forwarded to the Social Security Administration for further review. The Administration then notifies the claimant of the decision (III R. 13,14). (A pilot project is presently underway to forego the administrative review of reconsidered claims and to permit the full reconsideration determination to be made by the intermediary who had denied the claim in the first place).

If a claimant's case has been denied on the reconsideration review, and if his amount in controversy is $100 or more, he may next request a hearing before a Social Security hearing examiner, now known as an administrative law judge (42 USC 1395 ff; 20 CFR 422.203). Thereafter, an objecting claimant, upon request, may obtain review of the hearing examiner's decision from the Appeals Council (20 CFR 422.205). Following this, an individual dissatisfied with the final administrative decision of the Appeals Council can obtain judicial review under 42 USC 405(g) of a Part A claim only if the amount in controversy is $1000 or more (42 USC 1395 ff (b)).

Methodology of Part A Medicare Study

The effectiveness of any statutory program, such as Medicare, lies in its practical implementation. To determine the pertinent facts surrounding the implementation of the health insurance program, therefore, the following steps were taken:

1. All key administrative personnel were interviewed, including Mr. Thomas Tierney, Director of the Bureau of Health Insurance;
2. All key divisions in the Bureau of Health Insurance were visited, including Policy and Statistics;
3. Intermediary operations were studied in California, Connecticut, Illinois, Nebraska, New York and West Virginia, and the Bureau of Direct Reimbursement, with a special trip included to the national Blue Cross headquarters (BCA) in Chicago;
4. Administrative review processes were analyzed and discussed in depth with representatives from the Bureau of Hearings and Appeals;
5. All Medicare litigation, covering all beneficiary appeals for judicial review since the inception of the program, was examined to determine significant trends.

The Part A Medicare Actual Operation

Because of the political climate in which Title XVIII was originally enacted, the government posture was "hands-off," as stated in Section 1801 of the Social Security Act, 42 USC 1395 (a), entitled *Prohibition Against Any Federal Interference:*

> "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

Accordingly, the entire Medicare program evolved as a system paid for by the Government but operated by the private health care sector, including providers and fiscal intermediaries. The top standards for hospital participation, for instance, were those set by the Joint Commission for the Accredition of Hospitals, except for the Utilization Review Committee requirement imposed by the statute. Blue Cross plans and other private insurance companies, similarly, were entrusted with the complete responsibility of deciding which cases should be paid and how much the payments should be.

It is true that some instructions from the Government are relayed to the intermediaries through Intermediary Letters and occasional Manual additions or changes. It is true that proper intermediary performance is implicit in the written agreement signed by the intermediary. However, it is also true that where there is a failure of proper intermediary performance and/or non-compliance with specific instructions, there is no recourse available to the Government except to terminate the Part A agreement — and this indeed is a drastic measure.

In the most significant area of claims review as well, there is little or no precise direction given to the intermediaries as to how to manage this extremely important responsibility. As a result, some intermediaries allow clerks to judge cases and make decisions as to payment or denial; other intermediaries employ registered nurses to make such judgments; and still others (a minority) insist upon a medical review by a physician before any denial can be effectuated. Similarly, there is great disparity to be found in the degree of record-gathering and medical data required by an intermediary before any final decision will be made. Additionally, the kinds of denial letters written to disappointed beneficiaries, the time within which claims are processed, even the amounts allowed for hospitalizations and related care, all vary from intermediary to intermediary.

What this means in practical effect is that beneficiaries who contribute the same amounts each, to the same government, receive varying levels of fairness in determinations and amounts of benefits. This means that 83 intermediaries, who manage the most serious aspect of the Medicare program and decide who and what is covered thereunder, can and often do dole out 83 varieties of justice and payments.

Among four of the intermediaries visited, by way of illustration, the following disparities came to light:

	Original Reviewer	Denial Reviewer	Approximate Number of Denials
Intermediary 1	R.N.	R.N.	17-18%
Intermediary 2	Clerk	M.D.	6.9%
Intermediary 3	Clerk	M.D.	5%*
Intermediary 4	Clerk	R.N.	13%

*Rate until recently was 35%.

The Denial Syndrome in Medicare and Why

Obviously, a sampling of four intermediaries would not support general conclusions. It does reflect, however, the overall opinion expressed throughout all levels at the Bureau of Health Insurance. "The beneficiary in Appalachia," said one official, "does not get the same kind of deal that a beneficiary in California gets." Another commented: "We've got one program but too many versions. Where you get such variety in application, someone must be getting the short end of the stick."

This so-called "short end of the stick" is essentially what has been causing tremendous negative reaction to the

Medicare program throughout the country. The ever-increasing load of administrative appeals and court actions for judicial review, as well as the comments in the professional and public press, all testify to the fact that beneficiary claims are being denied and beneficiaries are bewildered and frustrated by the denials.

Even the Social Security statistics (as shown in the attached chart) show denials of claims over the entire nation that bear out the consumer complaints. Of a total of 8,585,400 Part A claims processed in Fiscal Year 1971, there were 215,500 claims *denied in full* (15.5 percent in extended care facilities and 0.8 percent in hospitals). This does not show the number of claims denied *in part*, of which there are an admittedly even larger number. And while 15.5 percent of total rejections in extended care facilities and 0.8 percent of total rejections in hospitals may not in itself sound impressive, these represent close to 300,000 dissatisfied people plus their families, not counting thousands of others whose claims were rejected *in part*.

In addition, these figures do not allow for the countless denials that swept the nation in the period before 1971 to such an extent that the resultant outcry caused a relaxation of the payment rules. Nor, finally, even if the number of denials were truly minimal—which it is decidely not—would such a statistical percentage be any consolation to the persons who fall within the exceptional deprived category, especially, as in the Medicare program, when the reasons for the deprivation of benefits are usually obscure.

For the fact is that there is regrettable obscurity and complexity in the Medicare program. A careful study of all the court cases to date establishes without doubt that there is difficulty even in making the judiciary comprehend what the statute means in some particularly clouded areas. Analysis of the issues in controversy in all cases reveals that most litigation revolves about questions of what is "custodial care," when is an emergency an emergency within the sense of the statute, and how does one distinguish between "entitlement to benefits" and entitlement in connection with a bill for an amount of benefits to be paid. Surely, if there is such difficulty for judges in interpreting the law, it would be absurd to expect elderly, sick men and women to understand the legal rationale behind denials.

From the point of view of these elderly, sick citizens, Medicare is too often looked upon as a legal decoy and the Government as a capricious hard arbiter. Their illnesses and general debilitation are real, yet they are told that although they are sick enough to die, they are not sick enough to have their hospitalization covered by the program.

To make matters worse, they are often told this months after they have incurred hospital expenses. Retroactive denials, in fact, have been one of the most painful sore spots in the Medicare program. To be denied payment when you believe you merit payment is frustrating; to be denied payment *retroactively* when you have expected payment and not been otherwise informed, is inevitably infuriating.

Granted that there is an appeals process to which an aggrieved beneficiary can resort. Some individuals, however, are too infirm or frightened to do battle with a bureaucracy. Others are too poor or too unknowledgeable to seek legal counsel. Besides, even where remedies are sought, the time and complexity of the system are in themselves disheartening.

Consider the statistics: in 1971, 25,854 beneficiaries requested reconsideration determinations for Part A claims; 1,454 requested hearings; and 374 requested Appeals Council review. Each step of the process gives a beneficiary six months from the last denial to file for the next step, and each next step takes from four to six months to process from the time of filing. In all, it takes about two years for a case to get on the calendar in court; and the fact is that by such time more than 90 percent of the beneficiaries have died-thinking that they or their families still were in debt. It is indeed the exceptional case that is waged in the name of the beneficiary himself. Most actions are maintained by representatives or executors of the estate of the deceased—usually family members who are extremely bitter.

Part A Medicare: An Analysis

The deficiencies that plague the operation of the Medicare program are generally conceded by all those involved. At all levels of the Social Security Administration, concern was expressed over the inequities in the claims review processes, the great variation in intermediary performance, the backlog in administrative review, the negative impact in retroactive denials, and the disparities in actual amounts of benefit payments.

And there is great reason for this concern. Not only has the Social Security Administration borne the brunt of complaint from physicians and beneficiaries alike, but there has been another consequence that is even more serious. As the denial rate has grown, in extended care facilities especially, more and more ECF's have begun dropping out of the program rather than risk being stuck with bills for services rendered which beneficiaries cannot or will not pay.

When the ECF portion of the Medicare program became effective on January 1, 1967, there were 3,669 facilities containing 262,321 beds that were certified for participation. There was a steady growth in the number of certified facilities and available beds through the end of 1969 when a program high of 4,849 facilities and 360,049 beds was obtained. Since this time and through March 31, 1971 (the latest available data) there has been a steady decline in both participating ECF's and total beds to 4,397 facilities and 311,946 beds. This represents a decrease in the 15-month period of 452 facilities and 48,103 beds (9.3 and 13.3 percent respectively).

This decline in participating facilities, moreover, is of great significance to the Medicare program. It means that there are fewer beds available to beneficiaries. It also means that there is increased likeihood that patients ready for transfer to ECF's may have to stay longer in more costly hospital beds because there is no other place to take them. It means, in short, practical curtailment of the ECF Medicare operation.

In the field, all intermediary personnel interviewed deplored the same general aspects of the program. In addition, the need for closer government direction and specific guidelines for claims review was repeatedly voiced. The suggestion was frequently made that there should also be greater educational efforts undertaken to explain the program more honestly to an oversold, confused public and to an almost equally confused provider world. The opinion was thoughtfully offered that the problem of retroactive denials was inherent in the present operational system of the Medicare program and could only be curbed by such drastic measures as an insistence upon the submission of regular 15-day bills; or the housing of a Medicare resident nurse in each institution to monitor cases on the spot; or even, in hardship situations, to allow payment for non-covered care.

The desperate need to make the public understand what covered and non-covered care means was another subject brought up again and again, both in and out of the Social Security Administration. Educational efforts, it was constantly maintained, must be undertaken. Only through public understanding of the limitations imposed by the Medicare statute on the program could an improved relationship be established among all concerned.

Less constant but still frequent were the references to the utter lack of any quality standards in the Medicare payouts. Utilization Review Committees, it was stated, are but cost control mechanisms, designed to see that beds are emptied as soon as possible. Where billions of dollars are being spent, the opinion was repeatedly held that the quality of services as well as the cost should be relevant.

Finally, it is interesting to note the undercurrent of bad feeling between the Blue Cross plans and the private intermediaries that is slowly but clearly perceptible and that obviously has an unfortunate effect upon the entire program. Because the "Blues" constitute an overwhelming majority of the intermediaries (73 out of 83), it is they—or so a great many intermediaries believe—who really run the Medicare program and exercise the "clout" in the operation. And whether this is so or not, the fact remains that private intermediaries and Blue Cross intermediaries almost never sit down together. As a result of this, an extremely and necessarily cost conscious Administration must hold, in duplication and at needless expense, separate briefings and other sessions for each group of intermediaries.

Part A Medicare: Recommendations

No one encountered throughout this study disputed the urgent need for change and improvement in the Medicare program. The Social Security Administration itself—a most sincerely and highly motivated organization—has repeatedly undertaken revisionary efforts to better the operation of the program and increase overall satisfaction.

It has instituted, for example, the "Resident Rep" system, whereby skilled Medicare personnel are placed in some of the larger intermediaries for the purpose, among others, of making on-site observations of intermediary performance. It has tried—unsuccessly—to clarify troublesome points in the statute through regulatory changes in an attempt to better define "custodial care," "skilled nursing services," "emergency care" etcetera. It is presently testing a new approach to the reconsideration process by turning the job over to the intermediary who made the original denial upon which the reconsideration is based—although this innovation has raised two significant comments: 1. In the current judicial climate that is zealous in its protection of constitutional due process, might not a review by the judge who made the initial decision be regarded unfavorably? 2. If an intermediary can make an in-depth review of a denial case for reconsideration purposes, why should it not, in the interests of justice, do so originally?

Nevertheless, even with the most recent HR 1 amendents to Title XVIII, some of the most critical areas in the Part A Medicare operation have yet to be resolved. The entire intermediary claims review process can and should be altered so that each beneficiary, wherever he lives, can be assured of skilled, fair, prompt and equal consideration of his case. The independence and latitude in operation that the Government has granted to its intermediaries, who are, both by statute and by judicial decree, agents of the Government, must give way to responsible, Federal direction.

A pattern for a model claims review process can be pieced together from the best that is available in fact, as well as from the best that has been suggested in theory. Beginning with the initial screening down to the last verdict of denial, there is no reason why knowledgeable, equitable methods cannot be employed.

For example, both in the Government's own Direct Reimbursement Branch and in a California plan, no negative payment decision can be made by anyone except a medical doctor. Both these intermediaries employ 10 or 11 part-time physicians who are otherwise in active, local practice to review any case where less skilled personnel have questioned coverage or need for the medical care rendered. On this basis, they maintain, there is no need for an expensive, full-time medical director on hand; and the original examination of a case can be entrusted safely to trained clerks, supervised by a few registered nurses.

In addition—although this is not now done anywhere—it is perfectly feasible to make an in-depth review of every denied case, just as the intermediary does at the present time for every denied case where a beneficiary files a "Request for Reconsideration." Investigation has revealed that most denials are made on the basis of a brief billing form that gives very little medical information for the decision. Reconsideration reviews, which compel the intermediary to establish a complete medical record, result in a reversal rate of previous denials of about 18 percent by the

SSA. Accordingly, to institute a system of automatic reconsideration on the intermediary level would probably result in fewer denials and more equitable denials. The intermediary would have to support denial decisions by substantial medical records and would, in essence, thereby grant prompt reconsideration to every denied beneficiary even when he has not known enough to request this. By the same token, automatic reconsideration would eliminate one step in the formal administrative review process and would begin this process, instead, with a hearing. (The constitutional aspect of a denial of benefits without a hearing, in keeping with *Goldberg vs Kelly*,[2] is being challenged presently in the courts in a pending appeal in the case of *Martinez vs Richardson.*)

From the point of view of the beneficiary, this entire approach would be more fair and have favorable psychological impact. Not only would he be relieved of the burden of the reconsideration step now employed in the administrative review process, but he would begin his Government contact with a person-to-person confrontation in the hearing room. This indeed would be more satisfying and real than merely a written letter. It would also speed up the time involved in reaching the hearing stage and all subsequent stages of the review process; and it should lead to better understanding on the beneficiary's part of what his denial is all about and why. The direct questions he can ask and the simple but comprehensive explanations that an administrative law judge should be trained to make, would inevitably mitigate the confusion that has evoked derision and rebuke from participants in the Medicare program.

This kind of overall revamping of the Government intermediary relationship and the development of specific, mandatory guidelines for claims review should include other modifications designed also to augment general understanding and to improve public reaction to the program. Illustratively: the letter informing a patient of the disallowance of a claim is almost always a form letter which refers to the appropriate statutory provision and language but falls far short of being either personal in tone or comprehensible as to its meaning. Why should this be? Similarly, although a certain amount of retroactive denials is inherent in the operation of the program (with hospitalization preceding billing as it does), much of this retroactivity can be curtailed by the institution of some of the heroic measures suggested by the intermediaries themselves: make billing mandatory every 15 days; or house a Medicare registered nurse in a provider institution (or have one nurse rotate to several providers) to monitor cases on the spot; or even, in hardship cases, allow payment for non-covered care.

Perhaps, too, retroactive denials can be curbed in other ways. The Government is now testing an "Assurance of Payment" plan, which cannot be applied across the board, unfortunately, but which does attempt to guarantee payment to selected providers for short periods of time. Another proposal, more in the extreme category, is that if an intermediary takes more than a specified reasonable time in which to process a claim and notify the beneficiary one way or the other, then said intermediary should thereafter be estopped from denying payment.

As important as anything else in the Medicare operation, however, is the urgent need to convert the national confusion therewith to clarity, and the frustration to fulfillment. Unquestionably, as all sources lament, the Medicare program has been oversold to the public. It is not a simple, all-encompassing panacea to meet all the medical needs of the aged. It is a significant step forward in that direction, to be sure, but it is also a complex and limited program designed to give assistance to the elderly *only* for acute illnesses, not chronic ones, unless there are acute exacerbations of these chronic conditions. It is for these reasons, moreover, that judgmental decisions as to covered care can be so difficult to make. It is perplexing even to skilled physicians, who alone should make them, to attempt to establish that debatable point where a chronic condition with an acute exacerbation which is covered under Medicare reverts to being a chronic condition which is excluded.

Obviously, a major educational enlightenment must be accomplished. One highly placed Bureau of Health Insurance executive has opted repeatedly for a written contract of insurance to be given to each new beneficiary, as in any private health insurance policy, with all the non-covered exceptions spelled out. Another official dreams of a series of television dramas (Marcus Welby style) to teach the viewers what Medicare is all about. Whatever the methods, however, one thing is clear: doctors, hospitals, patients and patients' families must learn the real facts of Medicare life. Even the judicary and legal profession need to know. Somehow, and as soon as possible, written explanations and informative lectures must be forthcoming to explain such things as the extended care concept and how it is distinguished from nursing home services (even though HR 1 has reinstituted the term "nursing home"); what "entitlement" means; what a Medicare emergency is; etcetera.

In addition to educational enlightenment of the public, however, it has been suggested that a permanent unit be created in the Bureau of Health Insurance to protect and further the rights and interests of beneficiaries under the program. Such a group could serve as a beneficiary advocate to the Government in all Medicare matters and it would be psychologically reassuring to the beneficiary that consumer interests were being adequately represented.

Finally, where there has been open pessimism about the possibility of reeducation of an over-expectant public to the limited realities of Medicare, a further recommendation has been made. Several top SSA officials have indicated approval of the idea that legislative enlargement be enacted to increase Medicare coverage and to include the formulation of quality standards of care for the program.

This educational program can be done and it must be done. No one, however remotely connected with the Medicare program, disagrees. Nor do they disagree with the finding that the operation of the Medicare program to date has roused much ire, and has been an extremely disruptive factor in the provider-patient relationship during this critical period of time when the malpractice phenomenon is already a serious threat in this area and when the entire health care system is under attack.

In fact, the only hesitation voiced in response to any and all projected remedial action has been that of cost. Such objections, however, have no validity.

Medicare is the first major government step in the health insurance field. Inevitably and understandably, there has been trial and error in the development of its operation. Further analysis and improvement can only, in the long run, produce the greatest economies of all: increased efficiency, social betterment and general satisfaction in return for all the billions that will continue to be spent.

TABLE 1
MEDICARE: NUMBER OF PART A CLAIMS PROCESSED AND DENIED AND DECISIONS ON RECONSIDERATION REQUESTS, HEARING REQUESTS, AND APPEALS COUNCIL REVIEWS, FISCAL YEAR 1971

	Inpatient hospital		Extended care facility		Home Health		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total claims processed.......	6,779,500	100.0	805,500	100.0	1,000,400**	100.0	8,585,400	100.0
Claims denied*............	52,500	0.8	125,200	15.5	37,800**	3.8	215,500	2.5
Reconsideration requests***..	9,148	100.0	15,490	100.0	1,216	100.0	25,854	100.0
Reversed in full..........	636	7.0	1,362	8.8	94	7.7	2,092	8.1
Reversed in part..........	708	7.7	1,169	7.5	92	7.6	1,969	7.6
Affirmed..............	7,804	85.3	12,959	83.7	1,030	84.7	21,793	84.3
Hearing requests†...........	411	100.0	1,030	100.0	13	100.0	1,454	100.0
Reversed in full..........	160	38.9	350	34.0	5	38.5	515	35.4
Reversed in part..........	10	2.4	14	1.3	1	7.7	25	1.7
Affirmed................	241	58.7	666	64.7	7	53.8	914	62.9
Appeals Council requests......	88	100.0	286	100.0	---	---	374	100.0
Favorable to claimant......	11	12.5	29	10.0	---	---	40	10.7
Unfavorable to claimant....	77	87.5	257	89.9	---	---	334	89.3

*Includes only those claims denied in full.

**Includes Part A and Part B claims.

***Processed in Reconsideration Branch of the Social Security Administration.

†Hearings returned to Reconsideration Branch from Bureau of Hearings and Appeals, SSA.

NOTE: --- indicates no cases.

TABLE 2
TOTAL PARTICIPATING ECF'S AND BEDS, INCLUDING NET GAIN OR LOSS FROM TERMINATIONS AND ACCRETIONS FOR CALENDAR YEARS ENDING 1967-70

Calendar Year	Total		Accretions*		Terminations**		Net Gain or Loss	
Ending	ECF'S	Beds	ECF'S	Beds	ECF'S	Beds	ECF'S	Beds
12/31/67	4405	308,843	810	52,742	74	6220	+736	+46,522
12/31/68	4787	337,937	697	49,888	315	20,794	+382	+29,094
12/31/69	4786	360,049	698	60,945	699	38,833	-1	+22,112
12/31/70	4511	325,415	519	36,869	794	71,505	-275	- 34,634
12/31/71			164		575		-411	

*Represents newly certified facilities and beds during calendar year

**Represents facilities terminated (voluntary and involuntary) and bed loss during calendar year

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

January 11, 1973

REFER TO:
HI:BD

OFFICE OF THE COMMISSIONER

Mr. Eli P. Bernzweig, Executive Director
Secretary's Commission on Medical
Malpractice
Department of Health, Education, and Welfare
DONO 4148
Washington, D.C. 20201

Dear Mr. Bernzweig:

I understand a summary memorandum prepared by Mrs. Evelyn Bradford and addressed to the members of the Secretary's Commission on Medical Malpractice may be included in your final report. For the record, this memorandum was not made available to us until after copies had already been made available to members of the Commission.

As you know from prior correspondence and from your participation in a meeting of the Health Insurance Benefits Advisory Council, the Social Security Administration has cooperated in every way it could in assisting the Commission on malpractice to analyze the phenomenon of increasing numbers of malpractice suits and the possible effect of this phenomenon on the costs of the Medicare program. We, of course, would be vitally interested also in any substantive data which might indicate that the Medicare program itself was playing any causative role in increasing malpractice claims. We continue to share with the Secretary's Commission a commitment to develop the facts in either situation.

I must say to you that I do not feel that the memorandum in question serves either of our concerns or our purpose in this regard. It is based entirely, as I see it, on the premise that denial of payment because of statutory limitations generates discontent and the further hypothesis that if there be discontent litigation must follow. Mrs. Bradford, however, did not present any evidence to support such a conclusion and, indeed, I believe her research failed to turn up even one single case of a malpractice action resulting from a denial of a Medicare claim.

The repeated assertion, such as, "...at all levels of the Social Security Administration, concern was expressed over the inequities in the claims review process..." and "...the overall opinion expressed throughout all levels in the Bureau of Health Insurance..." coupled with the representation that"...all key administrative personnel were interviewed, including Mr. Thomas Tierney, Director of the Bureau of Health Insurance..." would certainly lead one to believe that there is concurrence in the rationale and in the conclusions of the paper. Nothing could be further from the truth.

The Department, as you undoubtedly know, supported provisions ultimately enacted into Public Law 92-603 which will go a long way towards solving many of the problems which have existed in the past. Not one word describing those solutions is contained in the memorandum. In addition, the new law, for the very first time, introduces partial relief to the malpractice problem in the provision with regard to Professional Standards Review Organizations. Nothing is said in the memorandum about what would seem to be one of the most significant steps ever taken in Federal legislation with regard to malpractice.

There are aspects of the paper which do define administrative problems which have as yet not been totally solved even though there would appear to be no connection between these problems and the whole question of malpractice. You may be assured that we are aware of these problems and are continually working toward their solution. In fairness to the Medicare program and so that the Commission members or the public may not be misled, I would hope that you will make copies of this letter a part of your record.

Sincerely yours,

Robert M Ball
Robert M. Ball
Commissioner of Social Security

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

SECRETARY'S COMMISSION
ON
MEDICAL MALPRACTICE

February 6, 1973

Honorable Robert M. Ball
Commissioner of Social Security
Department of Health, Education,
and Welfare
Social Security Administration
Baltimore, Maryland 21235

Dear Commissioner Ball:

This is in response to your letter of January 11, 1973, commenting on the staff paper on the Medicare program prepared for the Commission by Mrs. Evelyn Bradford.

The Commission was specifically directed by the Secretary to explore the relationship between the malpractice problem and the operation of Federally-funded health-care programs. In this context, Mrs. Bradford examined the operation of Medicare's Part A claims denial procedures in order to assess the equity and uniformity of those procedures and to determine their impact on the provider-patient relationship. The conclusions reached in her memorandum did not purport to be definitive conclusions of the 21-member Commission, nor were they presented as such. While you may differ with the conclusions in her paper, there were a number of Commission members who felt that they did touch upon a significant problem area: the enhanced malpractice claim potential of dissatisfied patients whose Medicare claims have been denied.

The Commission's discussion of this topic reflected its concern that the Medicare program's statutory limitations and restrictions may well be a factor influencing malpractice litigation. Because the Commission recognized the paucity of hard data supporting the above, it recommended a much broader, in-depth study of the issue. Although only passing reference was made in the staff paper to P.L. 92-603, the Commission debated the subject at length, and concluded that some of the new statutory provisions might further exacerbate provider-patient problems.

As requested, your comments will be made a part of the Commission's permanent record.

Sincerely,

Eli P. Bernzweig

Eli P. Bernzweig
Executive Director

A MEDICAL OPINION SURVEY OF PHYSICIANS' ATTITUDES ON MEDICAL MALPRACTICE

William R. Pabst, Ph.D.

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In December 1971 the magazine *Medical Opinion* published an article based upon the results of a survey questionnaire voluntarily completed by nearly a thousand physicians.[1] The survey showed that most respondents felt that the medical malpractice situation was getting worse, and they blamed the breakdown in communications between doctors and patients as well as aggressive malpractice lawyers. They placed peer review and laws limiting malpractice suits high on their list of suggested remedies. The analysis presented in the published article was necessarily general, but the editor, Byron Scott, made the computer-run information available to the Commission staff for additional analysis.

This non-published information makes possible a direct comparison between the opinions of those respondents who had been touched by malpractice threats or suits, and those who had never been involved in any malpractice situation. Forty-eight percent of the survey respondents reported that they had been touched with malpractice, including 17 percent sued, 27 percent threatened, and 4 percent who had a partner sued.

The remaining 52 percent had neither been sued nor threatened with malpractice. Whether this division between the 48 percent touched by medical malpractice and the 52 percent untouched reflects the national situation or not, a question not directly answered because of the low survey response rate and possible bias introduced, the 17 percent reporting actual suits does correspond to the 1962 survey of physicians showing that about one in six was involved in malpractice suits. The nearly equal division between those touched by malpractice and those untouched provides a satisfactory sample to test the difference in opinions between these two groups. This is the purpose of this analysis.

---

[1] "Physicians' Attitude Survey", *Medical Opinion,* December 1971, pp. 43-47. A mailed questionnaire was sent to 3000 physicians selected on a systematic sampling basis from the American Medical Association and the American Osteopathic Association lists. Responses were received from 967, but not all these answered all questions About 53 percent of the returns were from those in general practice, surgery or obstetrics and gynecology—high risk specialties. The Eastern sections were heavily represented in contrast to the Western ones.

This report was originally prepared as a background paper for the Secretary's Commission on Medical Malpractice, U.S. Department of Health, Education, and Welfare, Report No. SCMM-WP-MM.

What They Thought About the Malpractice Situation

The first opinion queried was whether the respondents thought the situation "worse than ever before," "about the same as always," "less of a problem than before," or whether "there is no malpractice problem." The returns showed that both groups agreed that the situation is "worse than ever before," with a slight but non-significant difference[2] between the two groups, as shown below:

Opinions on the Medical Malpractice Situation	420 Physicians Sued or Threatened	453 Physicians Not Sued Or Threatened
Worse now than ever before	80	75
About the same as always	18	22
Less of a problem than before	2	2
There is no malpractice problem	0	1
Total	100%	100%

The fact that three-quarters of the physicians who themselves have not been sued or threatened feel that the "situation is worse than ever" attests to their extensive malaise on this subject.

The Reasons They Gave

As to the reasons why the malpractice situation is worse, the physicians were asked to check from 9 alternatives the "single most common cause of malpractice suits today." The comparison below shows how the two groups of physicians responded.

Causes of Suits	420 Physicians Sued or Threatened	453 Physicians Not Sued Nor Threatened
Poor communication between physician and patient	37	44
Aggressive lawyers	30	22
Declining public regard for doctors	14	11
Increasing complexity of medical practice	8	9
Increasing public education about medicine	4	3
Just plain "bad medicine"	2	2
The current system of patient care	1	2
Poorly-trained physicians	0	1
Some other reason	4	6
Total	100%	100%

The response seems very much alike. Both groups place "poor communications" and "aggressive lawyers" at the top of the list. The rank order of all the causes is the same. Yet there are very significant differences between the two.

Although both put poor communication at the top of the list as the leading cause of malpractice suits, the response of those who have been touched by malpractice is significantly less (a Chi Square value of 4.3, 1 D.F., is between P = .05 and P = .02) than those not touched. Since poor communication between physician and patient is a physician characteristic, those not touched by malpractice tend to blame the physician more than the others do for the present state of affairs.

In contrast, "aggressive lawyers" is considered as a more important cause by those touched by malpractice. The difference between the two groups on this issue is statistically more significant (a Chi Square value of 5.5, 1 D.F. shows P = .02) and perhaps reveals the major difference in attitudes between the two groups. This cause lies outside the physician characteristics, and hence one can assume from the responses those touched by malpractice tend to blame others than themselves. On this issue of the causative role of aggressive lawyers, and on this alone, a difference between those sued and those threatened appears, with those sued tending to blame the lawyers even more than those only threatened. The actual experience of having been directly involved in a suit apparently changes the physician's attitude with respect to the effect of aggressive lawyers. The remaining seven causes of suits dwindle off in importance in the opinion of those responding.

If, however, the causes of malpractice suits in the eyes of the responding physicians are grouped into the class of "those causes within the medical profession," and those "outside the physician's control," then the apparent difference between the two groups of respondents becomes more pronounced. Those causes "within the medical profession" include "poor communication," "increasing complexity," "bad medicine," "current system of patient care," and "poorly-trained physicians." The causes outside the physicians control include all the others: "aggressive lawyers," "declining public regard for doctors," "increasing public education," and "some other reason." The abbreviated tally is as follows:

---

[2] Chi Square of 2.6 shows that a difference as big as 80-75 in a sample of this size might happen as frequently as 10 percent of the time on the basis of chance alone.

Causes	420 Physicians Sued or Threatened	453 Physicians Not Sued Nor Threatened
Within medical profession	48	53
Outside medical profession	52	42
Total	100%	100%

Now the difference in opinion is apparent. Those sued or threatened give a slight edge to those causes outside the medical profession, whereas those neither sued nor threatened see the causes largely within the medical profession. Statistically this difference is highly significant (Chi Square of 7.7, 1 D.F., P = .01). The difference appears to be highly understandable in human terms in that those who have not been enmeshed in malpractice suffer no personal self-criticism by blaming physicians.

Most Effective Technique for Alleviating the Malpractice Problem

The respondents had 8 choices of "the most effective technique for alleviating the malpractice problem." On this subject there was no significant difference between the two groups. Their responses ranked in the following order:

Remedial Techniques	397 Physicians Sued or Threatened	433 Physicians Not Sued Or Threatened
Laws limiting such suits	27	28
Peer review	20	22
Reduced court judgments	14	14
Public education	10	10
Government regulations	7	4
Better medical education	5	5
Improved insurance plans	2	3
Some other method	15	14
Total	100%	100%

Both groups of physicians look to laws limiting suits or reducing judgments as the preferred solution, whereas medical or educational improvements are further down the list. Little attention is paid to insurance, or to broad government regulations. This attention to legal remedies is consistent with the attitude toward aggressive lawyers. However, there is a deficiency in the study, since the respondents were not offered a choice for improving the communication between physician and patient, the reason cited most often by both groups as the major cause of malpractice suits.

Preferred Carrier of Malpractice Insurance

Notwithstanding the small regard for remedies via improved insurance plans shown in the preceding table, the doctors did respond to a question regarding the insurance carrier of choice.

Carriers of Choice	417 Physicians Sued or Threatened	449 Physicians Not Sued Or Threatened
A private firm	38	35
Medical specialty society	15	18
The American Medical Association	12	14
Makes no difference	11	11
Federal government	11	10
A private firm owned by physicians	10	9
State government	2	2
Some other type of carrier	1	1
Total	100%	100%

In these answers the private firm is highly favored, as it the specialty society, reflecting an apparent satisfaction with the present situation. The two groups of physicians are quite similar in their choices, the rank order being identical.

Conclusion

This survey has been used to test the difference in opinion between the two groups of physicians responding to the questionnaire: one group touched by malpractice and the other neither sued nor threatened.

The opinions shown by both groups seem to be very much the same. Both groups think that the medical malpractice situation is "worse than ever before." Both groups favor "laws limiting such suits," "peer review," and "reduced court judgments" as remedial techniques. Notwithstanding the low esteem for "improved insurance plans" as a remedy, both groups prefer insurance carriers to be "a private firm," "[their] specialty society," or the "American Medical Association," in that order, reflecting apparent satisfaction with the existing insurance situation despite the increasing premium costs.

The only major difference in opinion between the two groups is found in the causes of suits. Although both groups tend to see the major cause of suits to be "poor communication between physician and patient" and the secondary cause to be "aggressive lawyers," the relative importance given to these causal elements is substantially different. Those who have been touched with malpractice tend to blame those causes outside the medical profession slightly more (52 percent as against 48 percent) than those causes within the medical profession. Those neither sued nor threatened with malpractice place the emphasis on those causes within the medical profession as against those outside (58 percent versus 42 percent). Thus those who have not been touched by malpractice afford a loftier viewpoint in seeing the root of the problem either in themselves or in the limitations of their medical colleagues.

It is interesting that this difference in opinion as to the cause of malpractice does not seem to carry over into any other opinions raised by the survey. In these other opinions doctors seem much alike. Perhaps future surveys will touch upon more controversial topics or those in which the effect of malpractice suits or threats can be more easily measured.

THE MEDICAL MALPRACTICE LEGAL SYSTEM

Stephen K. Dietz
C. Bruce Baird
Lawrence Berul

Summary

Section I explains the specific objectives of the Legal System Study.

Section II describes the methodology used in the survey of lawyers which provided data for this research study. Actually, two surveys were conducted: (a) the National Survey in which mail questionnaires were sent to a random sample of about 800 lawyers in private practice in the United States, and (b) the Selective Survey in which about 400 additional lawyers known to be engaged in medical malpractice were surveyed by mail questionnaire or personnal interview. A description of the sample design, questionnaire development, coding, tabulation and analysis is also provided in this section on research methods. Completion rate statistics are also presented for both surveys. The second sub-section of Section II describes the methods used in the analysis of a sample of appellate cases in order to evaluate the influence of statutes, rules and legal doctrines.

Section III presents the statistical tables produced in the analysis along with a discussion of the implications of these results. The first part of Section III provides definitions of commonly used terminology and a discussion of the sample sizes and statistical accuracy of the survey results. The method of analyzing the personal interviews is also discussed. The subsection of Section III provide the major results.

Section III-B provides a study of claims screening behavior including annual rates of medical malpractice claims and cases among the nation's lawyers, the size of firms they are affiliated with, case acceptance rates and reasons for rejection of cases, the extent to which claimants seem to "shop around" for a lawyer, the criteria used for case acceptance as explained in personal interviews with malpractice lawyers and their case referral behavior.

Section III-C presents the results of an analysis of various aspects of case handling behavior including the docket delay and case duration distributions, the frequency with which cases are terminated by settlement, trial, or abandonment and the stage of proceedings when settled, the proportion of tried cases that are appealed, the plaintiff/defendant win rates and associated influence of defendant type and injury severity, dollar amount of recovery, components of recovery and factors that affect recovery, and lawyer attitudes and opinions expressed in personal interviews concerning medical advice, expert witness, impediments to settlement and judge and jury factors.

Section III-D is devoted to the contingent fee arrangement and its influence on medical malpractice litigation. The frequency of various fee arrangements is presented along with the distribution of contingent fee percentages used by plaintiff lawyers and hourly rates used by defense lawyers. The contingent fee earned by plaintiff lawyers is analytically converted into an "effective hourly fee", using the reported lawyer hours on the case and fee earned, in order to determine whether or not the contingent fee system allows excessive fees to be earned by plaintiff attorneys. The uncompensated plaintiff lawyer hours on cases lost by the plaintiff are also analyzed to see if these uncompensated cases constitute a substantial amount of lawyer time or are only minor effects. A methematical model is developed to describe a plaintiff attorney's case acceptance decision process. This model is then used, with parameters derived from survey data, to evaluate the common assertions that the contingent fee system encourages lawyers to (a) reject small meritorious claims, and (b) accept non-meritorious claims if the amount

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of recovery is very large. Lawyer attitudes on the influcence of the contingent fee arrangement are then analyzed based on results of the personal interviews.

Section III-E presents a discussion of the results of inquiries concerning legal combines. Very few lawyers had any experience with legal combines and few were even familiar with their formation and operation.

Section III-F presents the results of an analysis of legal rules, statutes and doctrines that influence medical malpractice case initiation and outcome based on an analysis of appellate decisions. A definition of key rules, doctrines and issues is provided, the most important doctrines are identified, the applicability by state is summarized and their impact on initiation and outcomes of appeals is analyzed.

Section IV presents the major findings and conclusions from this study. Section V provides recommendations for further research, and Section VI provides references listed in the text of the report.

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I. Background and Objectives

The objective of the Legal System Study was to analyze and describe the way in which the legal community handles medical malpractice litigation. This analysis was to be based on quantitative data obtained from lawyers concerning their operating practices as well as data on individual malpractice cases. Various hypotheses and common assertions were to be tested and evaluated. Specific objectives of the study are summarized below by major categories:

- *Claims Screening*
  1. Determine what fraction of claims of alleged malpractice are accepted versus rejected.
  2. Identify reasons for rejection and their relative frequencies.
  3. Describe lawyer acceptance criteria.
  4. Estimate national volume of malpractice claims and cases.
  5. Analyze reasons for referring cases to other lawyers.
- *Case Handling Behavior*
  1. Determine the case duration and docket delay distribution.
  2. Determine case outcome modes (frequency of tried, abandoned, settled and appealed cases) and stage of proceedings at settlement for settled cases.
  3. Determine plaintiff/defendant win rates and investigate the influence of severity of injury and type of defendant.
  4. Calculate the average gross recovery and recovery components and evaluate the influence of injury severity and defendant type on amount of recovery.
  5. Determine the relationship between plaintiff lawyer hours on a case and amount of recovery.
  6. Identify the sources of medical advice and expert witness used by lawyers and determine the extent of such use.
  7. Identify impediments to pretrial settlement.
  8. Describe the judge and jury influence in malpractice cases.
- *Contingent Fee Analysis*
  1. Describe types of fee arrangements and their frequency of use.
  2. Calculate the effective hourly fee for plaintiff lawyers operating under a contingent fee arrangement to determine if the contingent fee arrangement provides excessive fees to the plaintiff lawyer.
  3. Examine the extent to which plaintiff lawyers are uncompensated under the legal fee system when their client loses.
  4. Develop a mathematical model for lawyer acceptance of malpractice claims. From this model evaluate the assertions that (a) small but meritorious claims are likely to be rejected and (b) large but nonmeritorious claims are likely to be accepted.

5. Assess the influence of the contingent system on the incidence and disposition of claims.

- *Legal Combines*
  1. Determine lawyer awareness of legal combines.
  2. Describe their formation and operation.
- *Legal Doctrines*
  1. Identify and describe those rules, statutes and legal doctrines that have a major influence on medical malpractice litigation from an analysis of appellate decisions.
  2. Determine the applicability of each such doctrine by State and the associated dates of onset or demise.
  3. Evaluate the impact of doctrines, rules and statutes on outcome of appeals.
  4. Determine the influence of key doctrines on initiation of cases.

II. Research Methods

A. SURVEY OF LAWYERS

Sample Selection

The target population for this study was all lawyers in private practice in the United States. A subpopulation of primary interest was all lawyers who recently have engaged in medical malpractice cases. For this reason the study time frame selected was January 1, 1970 through September 1972. Two different samples were drawn. The first sample was selected randomly from the nation's private practice lawyers. This sample is projectable to the United States, and therefore is called the "National Survey." The second sample was a specially compiled list of lawyers known or believed to be engaged in medical malpractice litigation. This list was used for the "Selective Survey" which resulted in a larger sample of cases, but is not statistically projectable to the lawyer population of the United States, even though a geographical spread across the United States was obtained.

The combined samples consisted of 1,218 private practice attorneys. The initial sample size in each survey was:

National Survey -	809 lawyers by mail questionnaire
Selective Survey -	240 lawyers by mail questionnaire 169 lawyers for personal interview
Total	1,218

The sample frame for the "National Survey" was the Martindale-Hubbell Law Directory, which is arranged geographically by state and approximates the universe of lawyers in the United States. Several groups were excluded in the sample selection. Those excluded were patent attorneys, lawyers in government or the military, retired and inactive attorneys, and those attorneys working for banks or for corporations. Only private practice lawyers were selected from this directory to ensure that only those lawyers who might have handled or might potentially have handled medical malpractice cases during the study time frame were included.

In addition to the random sample of 809 lawyers in the National Survey, a list of 409 lawyers known or believed to have been engaged in malpractice litigation provided by the Secretary's Commission on Medical Malpractice (SCMM List) was obtained to insure an adequate number of cases for analysis. These 409 lawyers constituted the Selective Survey. A combination of personal interviews and mail questionnaires with telephone followup was used in the data collection. All lawyers in both surveys were asked the same questions, except that those lawyers personally interviewed in the Selective Survey were asked some additional in-depth questions. The sample of lawyers for the personal interviews came entirely from the SCMM list. A subsample of 169 lawyers were selected for personal interviews from those cities with heavy concentration of malpractice lawyers as listed in Table II-1 below. The reason for selecting cities with substantial numbers of lawyers from the SCMM list was to allow for some efficiency in the utilization of the attorneys conducting the interviews by avoiding substantial time loss in travel to many smaller cities.

The remaining 240 lawyers from the SCMM list and the 809 from the Martindale-Hubbell Directory received mail questionnaires.

TABLE II-1
CITIES IN PERSONAL INTERVIEWS

City	Number of Lawyers
Boston	8
Chicago	16
Fort Lauderdale/Hollywood	10
Los Angeles/San Diego	30
Miami	3
New York/North Jersey	33
Philadelphia	8
Pittsburgh/Youngstown	8
San Francisco/Oakland	38
Washington/Baltimore	12
Total	169

Questionnaire

The questionnaire was designed to obtain factual information to produce a quantitative picture of the legal system processes which have a direct relationship to the initiation, conduct and outcome of medical malpractice litigation. All questions were designed to be answered retrospectively from general knowledge without the need for file searches or compilations of data. The questionnaire is presented in Appendix A. The cover page of the questionnaire directs the respondent to check a box indicating whether he had screened or closed a malpractice case within the time frame covered by the survey. If he had no claims of alleged malpractice brought to him, he simply checked that box and returned the questionnaire. If he had one or more claims brought to him but no cases closed since January 1, 1970, he completed only five questions. If the respondent had accepted one or more cases for personal handling which were closed since January 1, 1970, he so indicated and completed all questions. (All respondents who had closed cases turned out to have also considered or screened cases within the time frame.)

The questionnaire, shown in Appendix A, is divided into three parts. Part I, the General Information Form, requests information about the respondent lawyer's practice, his screening of potential clients, fee arrangements and factors influencing acceptance and disposition of cases. Part II contains Individual Case Information Forms which were used to secure specific information on up to five of the respondent's most recent cases closed after January 1, 1970. Part III, the Personal Interview Data Form, is a more in-depth examination of points covered in Parts I and II as well as the respondent lawyer's opinions and observations about handling malpractice cases which are best answered in face-to-face interviews. To summarize, then, Parts I and II were used in the mail survey, and Parts I, II, and III in the personal interviews.

Mail Survey

As indicated earlier, the questionnaire was sent to 809 lawyers randomly selected from the Martindale-Hubbell Directory and 240 malpractice lawyers from the Commission lists. Included with the questionnaire and stamped return envelope was a cover letter from the executive Director of the Malpractice Commission explaining the purpose of the survey and urging the completion and immediate return of the questionnaire. As the questionnaires came back, they were systematically logged by identification number, edited for completeness, then sent on for coding and keypunching. Questions that were incomplete, or otherwise unclear, were set aside for later telephone and mail followup.

Two weeks after the mailing, the first wave of telephone followup was begun. In addition to completing unfinished questionnaires, a minimum of two attempts were made (at different times on different days) to make certain that a questionnaire had been received, to urge completion and return and to answer possible questions. As a result of this followup, duplicate questionnaires were sent immediately to about 50 lawyers who reported that they had not received the original questionnaires. An effort was also made to place a lawyer in one of three categories given on the cover of the questionnaire: Type 1—no claims of alleged malpractice brought to attention since January 1, 1970; Type 2—one or more claims brought to his attention but none handled which were closed since January 1, 1970; Type 3—one or more cases closed since January 1, 1970. This "lawyer type" information was collected in order to improve the accuracy of national projections of the extent to which the legal community is involved in malpractice litigation. During the fourth and sixth weeks after the initial mailing, attempts were made to telephone all nonrespondents in the National Sample to further reduce the nonresponse error.

Tables II-2 and II-3 show the mail survey return rate statistics.

Personal Interviews

The personal interviews were conducted in nine areas across the United States, by practicing attorneys from the staff of Legal Resources Incorporated under subcontract to Westat, Inc. These cities were selected from the SCMM list of lawyers engaged in malpractice litigation. Cities were selected to obtain a balance between concentration of medical malpractice lawyers and geographical spread across the United States.

TABLE II-2
MAIL SURVEY RESPONSE CATEGORIES

	(A) Number of Quest. Mailed	(B) Responses*	(C) Completed* Quest.	(D) Type 1**	(E) Type 2**	(F) Type 3**	(G) Deceased, Postal Returns, Refusals, etc.
Law Directory	809	632	603	473	90***	40***	29
Commission List	240	79	68	0	11	57	11
Total	1,049	711	671	473	101	97	40

*Includes all mail responses plus telephone responses of Type 1.

**Type 1 means no claims screened nor cases settled in time period.
Type 2 means some claims screened but no cases handled and closed in time period.
Type 3 means some cases screened and cases closed in time period.

***An additional 19 Type 2 and 28 Type 3 telephone responses were identified by type but were not completed and returned.

TABLE II-3
MAIL SURVEY RESPONSE RATES

Response Rate From Table II-2 Statistics	Law Directory	Commission List	Total
Return Rate (B/A)*	78%	33%	68%
Completion Rate (C) ÷ (A-G)	77%	30%	66%
Estimated Completion**,***,† Rate on Types 2 and 3 (E+F)/.27 (A-G)	62%	No Est.	No Est.

*Includes all mail responses plus telephone responses of Type 1.

**Type 1 means no claims screened nor cases settled in time period.
Type 2 means some claims screened but no cases handled and closed in time period.
Type 3 means some cases screened and cases closed in time period.

***An additional 19 Type 2 and 28 Type 3 telephone responses were identified by type but were not completed and returned.

†Telephone followup to classify nonrespondents showed 27 percent of all eligible in Law Directory were Types 2 or 3 based on successful classification of 90 percent of all classifiable in sample.

From one to three interviewers, depending on the number of potential respondents, visited each site over a six-week period. All 169 lawyers in the personal interview sample from the SCMM list were initially contacted two weeks before a scheduled visit by a letter explaining the study and were informed that they would be contacted in the future by a representative of the Commission. Telephone calls were made one week in advance of the scheduled visit to set up appointments. Once on site, the interviewer telephoned again to confirm the appointment. Table II-4 shows completion rate statistics for the personal interviews. An overall rate of 78 percent was obtained.

Coding, Editing, Tabulation and Analysis

The questionnaire was precoded before being mailed to respondents. However, completed questionnaires required extensive editing and custom coding because of incomplete responses. Each questionnaire was thoroughly examined by professional staff members and was also subjected to a computer edit. Because of the varying response rates from question to question, percentages in a particular table produced from the data are based on the number responding to the particular question(s) used for that table.

A systematic analysis plan was developed to process data collected in both surveys of lawyers. The analysis plan developed by Westat and reviewed and modified by the SCMM Staff was organized around major categories of investigation such as claims screening behavior, influence of contingent fee, etc. Within each major category various statistical tabulations, distributions and comparative statistics were carefully specified and a computer program was written to produce the necessary tabulations and statistics. Most of the tabulations provide counts and percentages of one of the following:

1. lawyers
2. claims
3. cases
4. case-defendants

Furthermore, most tables were presented in six levels of aggregation:

1. National Survey - Plaintiff lawyers and cases
2. National Survey - Defendant lawyers and cases
3. National Survey - Both Plaintiff and Defendant
4. Selective Survey - Plaintiff lawyers and cases
5. Selective Survey - Defendant lawyers and cases
6. Selective Survey - Both Plaintiff and Defendant

Data from the two surveys (National and Selective) were not combined because of the vastly different sampling fractions used in drawing the samples which would have required weighting factors producing unacceptable high variance in the estimates derived from the data. Furthermore, the National Survey is a randomly selected and nationally projectable sample, while the Selective Survey is nonrandom and nonprojectable. The results of the analysis are presented throughout Section III.

A more thorough discussion of the sample sizes for the various categories analyzed is presented in Section III.A.

B. LEGAL DOCTRINES STUDY

This section describes the specific methodology applied to the legal doctrines portion of the study, which was conducted by Aspen Systems Corporation. The objective of this portion of the study was to determine whether specific legal doctrines, rules and statutes directly influence the initiation or the outcome of malpractice litigation and the applicability of these doctrines, rules and statutes in various States.

TABLE II-4
PERSONAL INTERVIEWS COMPLETION RATE

City	(A) Interview Complete	(B) Refusal	(C) Appointment Cancelled	(D) Not* Available	(E) No Malpractice	(F) No** Listing	(G) Other***	(H) Potential #
New York	4	4	2	5	4	1	1	21
Los Angeles	16	0	2	3	0	1	0	22
San Francisco	16	0	2	0	0	1	1	20
Chicago	13	0	2	1	0	0	0	16
Oakland	12	0	2	3	0	0	1	18
Wash/Balt	12	0	0	0	0	0	0	12
Philadelphia	5	1	0	1	0	1	0	8
Miami	4	0	0	0	0	2	0	6
Ft. Lauderdale	9	0	0	0	0	0	1	10
No. Jersey†	9	0	1	1	0	0	1	12
San Diego	4	0	0	4	0	0	0	8
Pitt/Youngtn	5	2	0	1	0	0	0	8
Boston	6	1	0	1	0	0	0	8
Total	115	8	11	20	4	6	5	169

*Not available during time period on site.
**No listing in city.
***Moved, deceased, etc.
†Newark, Elizabeth, and vicinity in New Jersey.
Completion Rate = (A) ÷ (H – B – E – F – G) = 115/146 = 78%

Analytical Approach

The basic approach taken was to compile and analyze a collection of reported appellate decisions in medical malpractice cases. The primary advantage of this approach was that appellate decisions are available in published form for all fifty states over a period of at least 70 years. It would be difficult, if not impossible to create a meaningful sample of trial records covering a representative sample of jurisdictions and years in the limited time available for the conduct of this study. It is recognized that appellate decisions represent only a small fraction of the total litigation and even a smaller fraction of the volume of claims processed. Further, the influence of various doctrines on the volume of appeals and on the outcome of these appeals cannot be projected to represent what actually happens to litigation at the trial level. Nevertheless, the results should provide a number of meaningful insights into how certain legal doctrines have evolved over time and how they may prevent or assist a claimant in establishing his case.

A random sample of all malpractice appellate decisions was taken. Each case in the sample was then analyzed to record basic data such as who won at the trial level, the results on appeal, the legal doctrines which were applied, which ones were most significant to the outcome of the appeal, the number of defendants, the amount of award, the type of injury and many other factors. This data was then coded and edited and tabulated by computer. These tabulations were then analyzed and the results were reviewed by a special panel of health lawyers with experience in medical malpractice law to help interpret the results and develop conclusions and recommendations. The highlights of the statistical analyses are presented in Section III–F. and the conclusions in Section IV.

A second component of the total effort was a manual search which identified the date of adoption or rejection of 10 significant legal doctrines in each of the 50 States and the District of Columbia. These results are summarized in Appendix B and are also reflected on several key figures in the test. (Section III–F.)

A third element of the study involved the inclusion of two specific questions in the several mail and personal interview surveys of attorneys which asked for opinions as to whether any particular doctrines, statutes or rules had a significant influence on their acceptance or processing of a malpractice case. The results of this study demonstrated a surprising degree of consistency with the analysis of appellate decisions (see Section III-F.)

Sample Selection

A comprehensive search of the American Law Reports (ALR) and the table of cited cases contained in Louisell and Williams' *Medical Malpractice* resulted in a list of approximately 4,200 reported decisions related to medical malpractice. Of these, 3,717 were appellate decisions. The balance were reported trial decisions from New York, California and the Federal District Courts which selectively reported trial decisions as well as appellate decisions. All of the analyses concerning number of cases, outcomes, class of defendant and award values are limited to the appellate cases. A few of the analyses concerning such peripheral factors as the diagnosis, treatment, severity of injury, type of treatment, alleged negligence, type of action, average number of defendants, and the like, are based on all of the reported cases in the sample.

One-third of all identified cases from 1950-1971 and one-sixth of all identified cases prior to 1950 were randomly sampled. While the contract did not require an analysis of the earlier cases, it was felt that a small sample would be justified in order to identify possible changes in trends prior to 1950. The actual distribution of the sample turned out to be 319 cases prior to 1950 and 781 after 1950 for a total of 1,100.

Review and Coding of Cases

Each case was reviewed, analyzed, and coded indepently by two different law students using a specially designed analysis form (see Appendix C-1). The key doctrines or issues involved in the case were identified and then one or at most two of these were marked as being most significant to the outcome of the case. The medical factors (ailment, treatment, and alleged negligence) were also extracted and reported.

All case analysis forms were reviewed by a supervisor and, where inconsistencies arose, were referred to a staff attorney for resolution. In addition, approximately 20 percent of the cases were randomly selected and reviewed by a staff attorney as a quality control measure. The legal doctrines or issues were then coded by the supervisor and staff attorneys using a list of doctrines developed empirically from the case analysis results.

The medical factors were coded by a medical records librarian using the same codes which had been used in the insurance closed claims study conducted by the SCMM.

Data Processing and Tabulation

The analysis sheets were transferred to input forms and keypunched. A wide variety of tabulations were prepared by computer processing.

The major variables in the tabulations were doctrines, outcomes (trial result, appeal results), states, and year. Other tabulations included type of defendant, severity of injury, diagnosis, treatment, alleged negligence, and type of plaintiff.

Tabulations were weighted by the sampling factors to represent projections of the total population of appellate cases over time. Where a case involved multiple defendants and different results, multiple sheets were prepared and the distinct results counted as separate cases. This coding of distinct case results as effectively separate cases results in only about a five percent increase over the actual number of cases.

Applicability of Key Doctrines

A manual search was conducted to identify the applicability of the ten leading doctrines in all 50 states and the District of Columbia. These results are summarized in Appendix B.

A special computer program was also written to sort the reported decision data base by state and by legal doctrine. The listing of each case with the outcomes at trial and appeal levels was used to double check the results of the manual effort. Considerable inconsistency was found since the judges rarely enunciate clearly the establishment or adoption of a "new" doctrine. The common law (our Anglo-American form of judge-made law) is fraught with semantic distinctions. What is or is not a particular "doctrine" changes with time as each reported case draws together the articulation of the law from older cases and applies it to fresh facts and new situations. As the "doctrine" is cited in later court decisions, it may be modified to the extent that it is substantially changed from that originally enunciated, although it may still carry the same label.

Analysis

A list of common assertions concerning medical malpractice was provided by the Commission. Various tabulations were prepared and studied to confirm or refute a number of these common assertions. These results were summarized and inferences were recorded and discussed with members of the consulting panel of health lawyers. Based on these discussions, as well as limited checks as to statistical reliability, conclusions and recommendations were developed.

III. Results and Discussion

A. INTRODUCTION

The results of the survey of lawyers are presented and discussed in subsections B through E. A separate study of legal doctrines, statutes and rules based on an analysis of appellate cases is presented in subsection F.

In the discussions that follow certain terms such as "claims", "cases", and so on, are used repeatedly without qualification. These terms are defined more carefully in Table III-1.

In the statistical tabulations presented in this section, a "floating base" has been used. That is, the number of respondents *answering* the question is the "total" used to derive percentages rather than the number *asked* the question. Thus as a result of differing question-to-question response rates, not all questions have exactly the same totals, even though most respondents answered nearly all the questions.

The accuracy of the survey results may be affected by (a) response error (due to misunderstanding of the question, misrepresentation, failure to remember accurately, etc.) and (b) sampling error due to limited sample sizes. No attempt has been made to estimate the response error. Table III-2 shows the size of the samples in both the National and Selective Surveys.

Error estimates derived from these sample sizes are presented in Table III-3.

TABLE III-1
TERMINOLOGY USED IN LEGAL SYSTEMS STUDY

Term	Meaning
Claim	A claim of alleged medical malpractice brought either formally or informally for a lawyer's consideration.
Case	A medical malpractice case. A claim becomes a case when a lawyer agrees to take the case and his client agrees to the fee arrangement.
Time Frame	The study time period about which lawyers were questioned: January 1, 1970–September, 1972 (a few questionnaires from personal interviews were extended into October, 1972).
Selective Survey	A survey of lawyers "believed to be engaged in medical malpractice litigation". For most of these "selected lawyers" malpractice litigation was an important, but by no means exclusive, part of their case load. Data was gathered by mail and personal interview using the same questionnaire as in the National Survey. Some additional questions were also asked in the personal interviews.
National Survey	A mail survey of private practice lawyers based on a random sample from a reasonably exhaustive national list. The results are projectable to the United States as a whole.
Case Duration	Time from accepting a case until it is closed (i.e., until the point of fixing the sum certain, even if zero).
Case *Won* by Plaintiff	A case is considered "won" by the plaintiff if he recovers any dollar amount greater than zero. This includes settlement amounts which may be less than he originally sought.
Cases Referred vs. Associated	In the legal profession it is considered unethical to accept a fee for "referring" a case. However, the original lawyer may pass a case along to another attorney and "associate with this other counsel". In the latter circumstance he is allowed to accept a fee for associating, although no specific level of effort on the case is required.

TABLE III-2
SAMPLE SIZE IN LAWYER SURVEYS

National Survey	Total	Plaintiff	Defense
Lawyers with claims or cases	130	120	10
Lawyers with closed cases	40	30	10
Claims - formal	533	419	114
- informal	496	483	13
- total	1,029	902	127
Cases	73*	45	25
Selective Survey	**Total**	**Plaintiff**	**Defense**
Lawyers with claims or cases	181	146	35
Lawyers with closed cases	167	132	35
Claims - formal	10,938	9,110	1,828
- informal	2,684	2,449	235
- total	13,622	11,559	2,063
Cases	497*	351	133

*These values are slightly larger than the sum for Plaintiff and Defendant since a few cases with lawyer type omitted were included.

In applying these error rates, the reader must be careful to note whether the discussion pertains to lawyers with claims or cases, only to lawyers who closed cases, numbers of cases, number of claims, etc. The sampling error estimates derived from measuring the sample sizes found in Table III-2 by the scale in Table III-3 turn out to be small except for tabulations of defense lawyers in the National Survey.

TABLE III-3
SAMPLING ERROR AS A FUNCTION OF SAMPLE SIZE

Sample Size	Sampling Error*	
	67% Confidence**	95% Confidence
20	± 11.2%	± 22.3%
50	± 7.1%	± 14.1%
100	± 5.0%	± 10.0%
200	± 3.5%	± 7.1%
400	± 2.5%	± 5.0%
1,000	± 1.6%	± 3.2%

*This is the "worst case" error in a proportion of .50, based on a normal approximation to the binomial distribution.

**That is, ± one standard deviation.

Some tables in this paper have sample sizes somewhat smaller than indicated in Table III-2 due to the floating base and because some tables deal with a subpopulation such as only tried cases. In the narrative discussion of results proportions are frequently compared. If sample sizes are small, yet the compared proportions appear substantially different, statistical significance tests have been applied. When the difference between two percentages, p_1 and p_2, is said to be "statistically significant", we simply mean that there is a high likelihood (e.g., .95) that the observed difference would not have occurred if the true values of p_1 and p_2 were equal.

The Selective Survey is treated as a special population of lawyers active in malpractice litigation, rather than a sample drawn from some larger, known population. Accordingly, statistical significance statements are not provided except for the National Survey. Results from the Selective Survey, including the personal interviews, are used primarily for comparison with the National Survey results. There is frequently a striking similarity between the results obtained from the two surveys. But occasionally there are substantial differences since lawyers in the Selective Survey tend to have heavier malpractice case loads and handle larger (i.e., higher recovery) cases. The reader is therefore cautioned about extrapolating results of the Selective Survey more broadly than the group of active medical malpractice lawyers studied in the Selective Survey.

Attorneys personally interviewed as part of the Selective Survey were asked additional "in-depth" questions and their responses analyzed in subsections B.5, B.6, C.6, C.7, C.8 and E.5 of Section III. In order to establish maximum respondent rapport, the interviews were conducted by practicing attorneys. Likewise, to ensure that only attorneys intimately familiar with the subject matter were interviewed, respondents were selected from a list compiled by members of the Secretary's Commission on Medical Malpractice who were known or believed to be dedicating a substantial proportion of their professional energies to the medical malpractice claims arena.

Geographic scope of the interviews by jurisdiction and the numbers of attorneys interviewed are shown in Table III-4. Also contained in the table are percentages of the total number of respondents versus the attorney's jurisdiction and whether he represented the plaintiff or defendant.

In drawing inferences (in the discussion which follows) from the statements by members of the plaintiff and defense bars, it should be noted that a substantially higher proportion of defense-oriented lawyers were included in the personal interviews than are reflected in mail questionnaire samples of all attorneys in private practice (a sampling from Martindale-Hubbell's Directory) or of those attorneys known to be engaging in the field of medical professional liability (SCMM list). Percentages of the populations, by plaintiff and defendant, are shown in Table III-5.

TABLE III-4
NUMBER OF PLAINTIFF AND DEFENSE ATTORNEYS INTERVIEWED BY JURISDICTION

Jurisdiction	Plaintiff Attorneys	Defense Attorneys	Total* Attorneys
California	25	18	46
District of Columbia	3	–	3
Florida	7	5	13
Illinois	12	2	15
Maryland	4	1	5
Massachusetts	6	–	6
New Jersey	9	–	9
New York	4	–	4
Ohio	1	1	2
Pennsylvania	6	2	8
Virginia	3	–	3
Totals	80 (70%)	29 (26%)	114 (100%)

*Includes five attorneys not classified as plaintiff or defense.

TABLE III-5
PERCENTAGES OF PLAINTIFF AND DEFENSE ATTORNEYS IN SAMPLED POPULATIONS

	Plaintiff	Defense	Total
A. All Atorneys in United States (Martindale-Hubbell)	92%	8%	100%
B. "Known" Medical Malpractice Practitioners (SCMM List)	81%	19%	100%
C. Personal Interviews of "Known" Medical Malpractice Practitioners (Note: C is a subset of B)	70%	26%	100%*

*Includes five attorneys not classified as plaintiff or defense.

In the personal interviews, "lead questions" were asked in order to stimulate discussion on topics of interest. Key phrases mentioned by respondents in reply to the question were recorded categorized and analyzed. It is important to note that the interviews were topical and broadly structured rather than simple responses to direct questions. Percentages for all responses were computed on a floating base, using as the denominator the numbers of lawyers who gave "some answer" in a particular area of topical interest. Multiple responses were allowed in the rules for data analysis so that in a number of instances combined percentages exceed 100.

B. CLAIMS SCREENING BY LAWYERS

Size of Law Firm

Survey results from both surveys show that lawyers that have screened malpractice claims, like most lawyers in private practice, tend to be associated with small law firms, small partnerships or as sole practitioners. The average size firm for the random sample of lawyers in the National Survey who had screened or closed medical malpractice cases is somewhat smaller than the average size firm among lawyers who had screened or closed cases in the Selective Survey.

Most of the lawyers with claims or cases tabulated above are plaintiff attorneys. The 35 defense lawyers in the Selective Survey are associated with firms that are four times as large as plaintiff lawyer firms, on the average. In the National Survey based on a smaller sample, defense firms are larger than plaintiff lawyer firms by a factor of two, on the average, as shown in Tables III-6 and III-7.

TABLE III-6
SIZE OF FIRM FOR LAWYERS WITH MALPRACTICE CLAIMS OR CASES

Size of Firm	National Survey	Selective Survey
1	21%	14%
2	14	18
3	21	15
4 - 5	22	17
6 - 10	7	20
11-50	12	13
Over 50	10	2
Total	100%	100%
Median Size	3.6	4.3

TABLE III-7
AVERAGE SIZE OF FIRM FOR LAWYERS WITH MALPRACTICE CLAIMS OR CASES

Survey	Average	Plaintiff	Defendant	Total
National	Mean	5	10*	5
Selective	Mean	5	24	8
National	Median	1.9	6*	3.6
Selective	Median	3.7	16.9	4.3

*Based on very limited sample of 10 lawyers.

Volume of Claims and Cases

Case Load

Although the number of medical malpractice cases per year in the United States is widely reported to have grown rapidly, medical malpractice cases still make up only a small part of a typical lawyer's case load. In fact, most lawyers in the National Survey had neither screened a medical malpractice claim nor closed a medical malpractice case in the study time frame (January 1970 - September 1972). The average or mean number of plaintiff cases per year per lawyer in the United States is only about .09. This low average partly reflects the fact that 73 percent of the private practice lawyers in the nation had no malpractice claims or cases in the study period. However, attention is focused on the 27 percent of the nation's lawyers who either closed or screened malpractice cases in the study time frame, we find a much larger average of .4 cases per year for plaintiff lawyers and 4.3 cases per year for defense lawyers. In our Selective Survey of "known malpractice lawyers" the average number of cases per year is much larger and the defense lawyer caseload exceeds the plaintiff lawyer caseload by a factor of 4.4.

Volume of Claims

Claims of medical malpractice are brought to lawyers' attention both formally (e.g., visit or call to lawyer's office) and informally (e.g., at a social gathering). Even if attention is restricted to only those plaintiff lawyers who had claims or cases in the study time frame, the number of claims per year is rather low nationally as shown in Table III-8 below.

TABLE III-8
AVERAGE NUMBER OF CASES PER YEAR ACCEPTED FOR PERSONAL HANDLING AMONG PLAINTIFF LAWYERS WITH MALPRACTICE CLAIMS OR CASES

	Plaintiff	Defense
National Survey	.4	4.3
Selective Survey	6.4	28.1

These figures show that nationally only about three claims per year are considered per lawyer even if we restrict our attention to plaintiff lawyers involved in screening claims during the study time frame. The above results also show that about half of the claims nationally are informally brought to the lawyer for consideration. The distribution of total claims per year is highly skewed so that the median number of claims is much smaller than the mean shown in Table III-9. In the National Survey the median was only 1.1 compared to a mean of 2.8. In the Selective Survey the median was 14 compared to a mean of 30.

TABLE III-9.
AVERAGE NUMBER OF CLAIMS PER YEAR AMONG PLAINTIFF LAWYERS WITH MALPRACTICE CLAIMS OR CASES

	Number of Formal Claims/Year	Number of Informal Claims/Year	Total Claims/ Year
National Survey	1.3	1.5	2.8
Selective Survey	23	6	30

The above figures from the Selective Survey exclude abnormally high numbers of claims reported in the personal interviews by six plaintiff lawyers who had an average of 858 formal claims per year each and virtually no informal claims. While this is an extraordinarily large number of claims, these respondents said they considered this number of claims and a few subsequent confirmation checks by telephone produced consistent response. These may be examples of true malpractice specialists or misestimation by these few respondents. In either event these responses are excluded in the above table so as not to greatly distort the distribution average by a few grossly abnormal responses.

National Totals

There were an estimated 225,000 private practice lawyers, excluding patent attorneys, in the United States in 1970 and about 237,000 in 1972 (based on American Bar Foundation Statistics adjusted for 1970 to 1972 changes). Applying the estimated lawyer population at the midpoint of the study time frame to the percentages obtained from the national survey of lawyers, rough estimates are formed for the time frame January 1, 1970 through September 1972 as shown in Table III-10.

TABLE III-10.
ESTIMATED NUMBER OF LAWYERS ENGAGED IN MALPRACTICE LITIGATION NATIONALLY

	Estimated Number of Lawyers in U.S. in Time Frame
Lawyers with no claims or cases closed	166,000
Lawyers with claims or cases closed	61,000
Lawyers with claims but no cases closed	42,000
Lawyers who closed cases in the time frame	19,000

The accuracy of these figures has been enhanced by an additional telephone followup to all nonrespondents in order to classify them according to their involvement with malpractice claims or cases. A 90 percent completion rate was obtained so that nonresponse bias should be reasonably low with regard to the above estimates.

Acceptance and Rejection of Claims by Lawyers and Referral of Cases

Acceptance Rate

Nationally about eight claims are reviewed for every one case accepted for personal handling based on results of the National Survey. However, among those plaintiff lawyers who had closed cases in the study time frame, about one-half of the formal claims brought to a lawyer for consideration are accepted as shown in Table III-11. Among known medical malpractice lawyers this fraction of accepted cases decreases to about one-quarter. Very few cases are associated with other counsel or referred to another lawyer.

TABLE III-11.
CASE ACCEPTANCE RATE AMONG PLAINTIFF LAWYERS WHO CLOSED CASES

	National Survey	Selective Survey
Accepted for personal handling	46%	27%
Associated other counsel	3%	1%
Referred to other counsel	1%	1%
Rejected	50%	71%
Total	100%	100%

Note that the 46 percent acceptance rate above is much higher for lawyers who closed medical malpractice cases than the corresponding rate of 12 percent (or one case per eight claims) for all lawyers who considered medical malpractice claims.

Shopping Around for a Lawyer

There is some concern that claimants with a case of alleged medical malpractice might "shop around until they find a lawyer to take their case". If this were a common phenomenon, it is suggested, there could well be some "double counting" of medical malpractice claims. The lawyer survey is not as well equipped as the consumer survey to determine the incidence of this claimant behavior. However, when asked, plaintiff lawyers with cases responded that they believed 17 percent of all claims (formal and informal) brought to them had been previously taken to another lawyer. This 17 percent probably includes claimants who were referred to a lawyer with more experience in medical malpractice as well as claimants who were "shopping around". There is no way to determine exactly how this 17 percent is subdivided from the data available. However, the previous subsection shows that referred and associated cases only total about four percent of the *formal* claims. It might well be expected that a higher percentage of informal claims find their way to a second lawyer. About all we can say from the data that we have is that "as far as lawyers can tell, no more than 11 percent of claims might be from claimants shopping around".

As might be expected, a much larger percentage of claims (49 percent) in the Selective Survey were believed to have been previously taken to another lawyer by plaintiff attorneys.

Reasons for Rejection

When given five possibilities as their major reason for rejecting claims, "no perceived liability" was the most common explanation provided by plaintiff lawyers as shown in Table III-12. In the Selective Survey, the three lawyers with an abnormally large number of claims were

TABLE III-12.
REASONS FOR REJECTING MALPRACTICE CLAIMS

	Percent of Rejected Formal Claims with this as the Major Reason	
Reasons for Rejection	National Survey	Selective Survey
No perceived liability	41%	56%
No damage suffered	6%	7%
Economic reasons	10%	23%
Statute of limitations had run	3%	4%
Other	40%	10%
Total	100%	100%

omitted so that a few lawyers would not be allowed to influence unduly the reasons for rejection distribution. If these three had been included, "no perceived liability" would have been cited over 60 percent of the time.

Economic reasons usually imply that the amount of potential recovery is too small to warrant the legal expenses that would be required. A more detailed discussion of lawyer acceptance criteria is provided in the next subsection based on personal interviews with lawyers.

The "other" category in the National Survey is unusally large (40 percent). A further breakdown of this category shows that routine referral of malpractice cases, difficulties with proof and conflict of interest are the most common other reasons reported.

"Other" Reason for Rejection	Number of Lawyers (National Survey)
Always refer malpractice cases	8
Difficulty in proving case	5
Conflict of interest	5
Difficulty getting medical testimony	2
Damage too limited to warrant cost	2
Client not a credible witness	1

Acceptance Criteria

During the personal interviews of attorneys known to be engaged in the prosecution and defense of medical malpractice claims, three areas were probed in-depth to ascertain the degree to which plaintiffs' attorneys act as a screening mechanism for insuring that only meritorious claims reach the formal stage of proceedings. These general areas of inquiry were explored by the following "lead questions":

(1) How do you decide to accept a malpractice case?
(2) In what percent of cases is there malpractice?
(3) Do malpractice claims require more time? By what factor?

Decision Criteria for Accepting a Medical Malpractice Case

Before reporting on the responses to these questions concerning case acceptance, it is appropriate to describe what the interviewers gleaned on the typical process used by plaintiff attorneys for screening or deciding to accept a medical malpractice case. That process is a three stage one. First, the attorney meets with the potential client, and evaluates the case in terms of liability and damages. Assuming the case appears to have a sufficient damage potential and possibility of malpractice, the attorney then obtains an opinion from a physician as to whether there was negligence. Third, if the physician's opinion corroborates negligence, he then accepts the case. This process is broken down into the five major factors displayed in Table III-13.

These statistics show that the decision by a plaintiff's attorney to accept or reject a medical malpractice case is almost overwhelmingly dependent on or in alliance with the medical community, a factor mentioned by 99 percent of those responding. This dependence is based on the need for an expert factual opinion on which to base a threshold decision: whether a break of medical duty occurred and whether it was the factual cause of the claimant's injury.

TABLE III-13.
MAJOR DECISION CRITERIA FOR CASE ACCEPTANCE

Major Decision Criteria	Percent of Lawyers Giving Some Answer*		
	Total (N = 104)	Plaintiff (N = 80)	Defense (N = 24)
Economic Factors	44%	58%	0
Apparent Degree of Liability	42%	55%	0
Dependence on Alliance with Medical Community	88%	99%	58%
Client Factors	18%	24%	0
Other	28%	6%	100%

*Based on 104 lawyers responding, or 95 percent of those interviewed.

Second in importance of response by plaintiff's attorneys were economic factors—principally the provable money damages (50 percent of the responses), followed by a response indicating a concern for the degree of apparent liability (with 55 percent so responding).

Client factors including good faith and credibility of the witnesses were mentioned by 24 percent of the respondents.

The dominant factor in a defense attorney accepting a medical malpractice claim (noted by 100 percent of the defense attorney respondents) is the existence of an insurance company retainer agreement.

Economic Factors in Case Screening

Of the 58 percent of the 80 plaintiff lawyers providing some answer to the lead question, the economic factors mentioned by them are divided into four major factors, shown in Table III-14.

As noted in the table, about one-fourth of the plaintiff attorneys mentioned a requirement for substantial injury or

TABLE III-14.
ECONOMIC FACTORS IN CASE SCREENING

Economic Factor Mentioned	Percent of Plaintiff Attorneys Responding* (N = 80)
Substantial Injury or Damages Required	23%
A Specific Dollar Threshold Required	18%
Size of Case a General Factor	16%
Evaluation of Settlement Climate	1%
Total Mentioning	58%

*Based on 46 plaintiff attorneys responding, or 58% of 80 interviewed.

damages as a criterion in their case screening and acceptance. It is probable that since the respondents are representative of the more experienced and successful medical malpractice claims attorneys that this requirement is not reflective of the plaintiff's bar in general, but of the sophistication of the population from which the respondents were selected. However, as shown in Section III.B.5.c of this report, almost all attorneys interviewed reported that malpractice cases required significantly more time than other negligence matters, and it is accordingly possible that a dollar threshold is merely reflective of the apparent fact that the investment in a medical malpractice case is greater.

Second in importance, and supportive of the hypothesis of the high level of professional success attained by respondents, or perhaps the greater investment of resources required, is that 18 percent of them stated the requisite for a specific dollar threshold before they would accept a case. An additional 16 percent of the respondents mentioned the size of the case, but only as a general factor in the screening criterion. Only one percent of the respondents indicated any concern in case screening criterion with the climate for settlement—i.e., inclination of the insurance carrier or physician to settle.

Degree of Liability Perceived at Case Acceptance

Responses regarding the degree of liability required for case acceptance were categorized into four general gradations indicative of the attorney's perception of liability. The responses of plaintiffs' attorneys in this category are contained in Table III-15. Although there is some interpretive difficulty in doing so, the responses are ordered in the rows of the table in terms of their rank order (ranging from the least stringent to the most stringent) of acceptance criteria as the attorney perceives liability in his description of the case screening process. The table is constructed to show percentages based on the total number of lawyers interviewed. Forty-four lawyers (or 55 percent of those interviewed) gave responses which reasonably could be categorized into associating their case acceptance decision with their perception of liability.

TABLE III-15.
PERCEIVED LIABILITY

Rank Order	Degree Perceived	Percent of Plaintiff Attorneys Mentioning* (N = 80)
Least Stringent	Bad Medical Result Only	1%
↓	Theory Perceived After Review of Facts	10%
↓	Liability Apparent	35%
Most Stringent	Liability Clear or Obvious	9%
Total Mentioning		55%

*Based on 44 plaintiff attorneys responding, or 55% of 80 plaintiff attorneys interviewed.

Although physicians are frequently critical of attorneys for accepting cases and filing claims on the basis of a bad medical result only, it was apparent from the reported data that only one percent of the respondents articulated a willingness to accept a case on this tenuous inference of professional medical liability. Likewise, only nine percent of the respondents indicated a most stringent test, a finding of "clear" or "obvious" liability. Ten percent of the respondents indicated a practice of carefully reviewing the facts and accepting the case on the perception of a legal theory upon which recovery could be had. Far more than half of those mentioning their perception of liability as a factor in case screening, however, indicated that liability must be apparent upon their decision to accept a case.

Degree of Dependence On or Alliance With the Medical Community

Although the specific question as to the attorney's sources of medical information was asked later in the interview, 99 percent of the plaintiffs' attorneys responding mentioned their overwhelming concern with the need for medical expert testimony and advice at the case acceptance threshold. These responses are collected and categorized in Table III-16 for both plaintiff and defense attorneys.

It is of further interest that more than half of the defense attorneys responding mentioned the need for expert advice as a dominant factor in case screening. Responses in the table are ranked down the table in their subjective order of dependence by the attorney on the medical community. Despite the frequent assertion by physicians that many lawsuits are filed on unfounded factual situations, a mere three percent of the plaintiffs' attorneys responding indicated that their decision to accept a medical malpractice claim was based completely on their own assessment of the medical facts. At the other end of the spectrum, only five percent of the plaintiff's attorneys mentioned that they would accept a case only if an expert were available to testify.

Where opinions about the medical facts were obtained from physicians, two-thirds of those mentioning opinions stated that they were formal opinions, or opinions in writing for which a fee is charged. About one-third of the opinions were secured from physicians on an informal basis, either with or without payment. Six percent of the plaintiff attorneys responding indicated a pre-existing relationship with medical experts.

Almost half of the defense attorneys indicated their reliance on formal physicians' opinions, and only eight percent indicated a pre-existing relationship. However, the question was not designed specifically to determine whether pre-existing relationships existed, so that eight percent may be a low estimate. What is significant is that about the same percentage of plaintiff and defense respondents mentioned it. Also of interest in the differing responses between plaintiff and defense attorneys, is the far

TABLE III-16.
DEGREE OF DEPENDENCE ON OR ALLIANCE WITH THE MEDICAL COMMUNITY

Degree of Dependence or Alliance	Case Acceptance Medical Advice	Percent of Lawyers Mentioning*		
		Total (N = 104)	Plaintiff (N = 80)	Defense (N = 24)
Independent	None – Decision Completely by Lawyer	1%	3%	0
↓	Partially by Lawyer	18%	24%	0
	Informal Physician Opinions	18%	23%	4%
	Formal Physician Opinions	40%	39%	46%
	Pre-existing Relationship with Medical Expert	7%	6%	8%
Completely Dependent	Expert Available to Testify Required	4%	5%	0
Total Mentioning		88%	99%	58%

*Based on 79 plaintiff attorneys responding, or 99 percent of 80 giving some answer; and 14 defense attorneys responding, or 58 percent of 24 giving some answer.

greater degree of reliance by members of the plaintiffs' bar on informal opinions of physicians—the formal-to-informal opinion ratio for plaintiffs' lawyers was two to one, while the defense respondents' ratio was 11 to 1.

This question of how a plaintiff's attorney obtains expert medical information is discussed in a subsequent section of the report.

Client Factors

No attorney primarily representing medical defendants mentioned factors which dealt with the client as a consideration in screening the case for acceptance. Three factors were mentioned by plaintiffs' attorneys with frequency significant enough to record. Twenty-four percent of the 80 plaintiff attorneys giving some answer to the lead question, a surprising 12 percent indicated a concern with the client's motives or good faith in seeking to bring a medical malpractice claim. This high concern for a negative factor is indicative that these attorneys may, in fact, be performing their frequently-stated role of insulating the medical profession from unwarranted medical malpractice claims. The remaining client factors mentioned were six percent who expressed as a factor the credibility of the client as a witness, and six percent who mentioned a factor of whether the client's injury was permanent or demonstrable.

Other Factors

Miscellaneous factors include 100 percent of defense attorneys giving some answer to the lead question which indicated that their decision to accept a claim was based on an insurance company defense retainer agreement. Miscellaneous responses from members of the plaintiffs' bar included acceptance by referral from other plaintiffs' attorneys; an interest in apparent record tampering; and ethical conflict of interest problems.

Conclusions of Lawyers Attitudes and Behavior in Case Acceptance

There are several important conclusions from this array of lawyer attitudes and behavior in accepting and screening medical malpractice claims prior to accepting the case. First, the very high degree of concern by members of the plaintiffs' bar with obtaining a medical opinion before accepting a case and the high degree of unsolicited response and concern as to the client's motives or good faith. Both suggest that the plaintiffs' bar is professionally discharging its responsibilities to society and to the medical profession in screening medical malpractice claims. Physicians are providing plaintiffs' attorneys with informal opinions thusly evidencing a professional concern and regard for the quality of medical malpractice by physicians, irrespective of where the issue of liability ultimately may lead.

Lawyers' Estimates of Incidence of Medical Malpractice

While the respondents were interviewed primarily to elicit their case acceptance criterion, an estimate was obtained from them about the malpractice claims phenommenon as viewed from their perspective. In this analysis, the lead question was "In your opinion, in what percent of claims is there medical malpractice?". In Table III-17, the percentage response, major central tendency, and other statistics of these estimates are shown. In general, there was little, if any, recorded difference in their estimates of actual medical malpractice as an ingredient of the cases which they had reviewed. It is of interest that there was little difference between responses given by plaintiff and defense attorneys. This is somewhat surprising, for in the sequence of events, plaintiffs' attorneys are the first to screen cases. They would presumably reject those without merit. Defense attorneys, by contrast, should be confronted only with cases previously screened by plaintiffs' attorneys; yet the recorded percentage as estimated by both populations is about the same.

TABLE III-17.
LAWYERS PERCEPTION OF THE PERCENTAGE OF CLAIMS IN WHICH THERE WAS MEDICAL MALPRACTICE

Statistic	Plaintiff Lawyers	Defense Lawyers
Mean	33.5%	33.3%
Median	33%	30%
Mode	33%	20%
Range	5 - 100%	5 - 90%
Number Responding*	69 (86%)	23 (79%)

*Based on 92 attorneys responding or 84 percent of 109 interviewed.

Perhaps what the statistics show is that acceptance of cases by plaintiffs' attorneys is more nearly a random than a selective process or that the threshold by which members of the plaintiff and defense bars judge the merits of cases is different. It is also possible that the attorneys personally interviewed were among the "leading" trial lawyers, and, as such, received many referrals of cases which had already been screened.

The Complexity of Medical Malpractice Claims Processing

The interviews were designed to derive insight into professional attitudes and beliefs concerning the complexity of medical malpractice cases. This was done through the reflected dimension of the estimate of whether medical malpractice claims require more time. The lead question asked during the interviews was "In your opinion do medical malpractice cases require more time than other personal injury cases?". For those respondents answering in the affirmative who were able to estimate a given factor (expressed as a multiple, with one representing other personal injury cases) this response was also recorded.

Table III-18 indicates the results of this inquiry. Note that in the table there is little difference (approximately five percent) in the responses of members of the plaintiff and defense bars, with the plaintiff respondents indicating the slightly higher percentage. It can be concluded from the response that, overwhelmingly, attorneys for both the plaintiff and defense agree that medical malpractice claims require more time in processing than do other personal injury cases.

TABLE III-18.
RECORDED RESPONSES TO THE QUESTION "DO MEDICAL MALPRACTICE CLAIMS REQUIRE MORE TIME THAN OTHER PERSONAL INJURY CASES?"*

Answer	All Lawyers (N = 109)	Plaintiff Lawyers (N = 80)	Defense Lawyers (N = 29)
Yes	96%	98%	93%
No	4%	2%	7%

*Based on 100 percent of 109 lawyers responding.

The results of estimates of the factor by which medical malpractice claims require more time than do like personal injury claims are recorded in Table III-19. Although only 73 percent of the 109 lawyers interviewed gave a useful response to this question, there are major differences in the percentages of plaintiff (80 percent) and defense (55 percent) lawyers responding.

TABLE III-19.
ESTIMATED FACTOR BY WHICH MEDICAL MALPRACTICE CLAIMS REQUIRE MORE TIME THAN OTHER PERSONAL INJURY CASES

Statistic	Plaintiff Lawyers	Defense Lawyers
Mean	4.7	3.7
Median	4.0	3.5
Range	0.5 to 13.0	0.5 to 12.5
Number Responding*	64 (80%)	16 (55%)

*Based on 80 lawyers responding of 109 interviewed.

The results show that plaintiff lawyers tend to indicate a somewhat larger factor in their estimates of the additional time required on malpractice cases than did the defense respondents. Several explanations can be offered for this: one, the plaintiffs' attorney expends more time in deciding whether to accept a case; two, the plaintiffs' attorney has the burden of proof in court and therefore must present a stronger case than the defendant; three, the plaintiffs' attorney may spend more time in obtaining witnesses; and four, the plaintiffs' attorney may be overly conscious of time since he ordinarily accepts a case on a contingency fee basis. It should be recognized, however, that these presented statistics are based simply on the estimates of lawyers, and not recorded or measured hours in actual case preparation.

Reasons for Referral and Fee Arrangement Upon Referral

During the personal interviews of the selective survey, respondents were asked the lead questions:

(1) "Why do you refer cases?"
(2) "What is your fee upon referral?"

Referral Practices

Responses to these lead questions are categorized in Table III-20. Fully three-fourths of the total respondents indicated that they did not refer cases.

TABLE III-20.
REPORTED REFERRAL PRACTICES

Referral Practice	Percent Frequency Mentioned and Number Responding		
	Total (N = 95)	Plaintiff Attorneys (N = 73)	Defense Attorneys (N = 22)
Do Not Refer	74%	75%	68%
Ethical Conflict of Interest	15%	10%	32%
Potential Recovery Too Small	6%	8%	0
Case in Jurisdiction Where Not Admitted to Practice	3%	4%	0
Know Colleague With Greater Expertise	2%	1%	5%
Other	4%	5%	0

For those respondents who mentioned a specific set of circumstances under which they would refer a case, the ethical conflict of interest arose with greatest frequency. It is to be noted that all attorneys would undoubtedly disassociate themselves from representation should an ethical conflict of interest arise and that the figures presented in the table are reflective only of the apparent frequency with which such conflicts occur. The table shows that defense attorneys mentioned the ethical conflict of interest three times as frequently as did plaintiff attorneys.

Eight percent of the plaintiff attorneys giving some responses to the referral issue indicated that cases would be referred if the potential recovery were too small. This is perhaps indicative of the sophistication of the selected sample in their practice of law rather than a generalized attitude on the part of the bar.

A small fraction (four percent) of plaintiff attorneys indicated that cases would be referred where their prosecution was required in a jurisdiction where they were not admitted to practice. No defense attorney apparently had encountered these circumstances and there was no response in this category.

A small percentage of both plaintiff and defense attorneys indicated that referrals were made when they knew a colleague with greater expertise in the particular subject matter and although this reason was given with five times the frequency percentage of defense attorneys than members of the plaintiffs' bar, the number from which percentages were computed are too small to make a significant statistical difference.

Other factors were mentioned by plaintiffs' attorneys which indicated that referrals would be made if their immediate workload was too great to handle the case, that referrals were made only infrequently, or that a referral would be made in the event of an apparent personality conflict between attorney and client.

Referral Fees

The percentage of the contingent fee paid to the referring attorney was also explored by the aforementioned lead question. The responses by 60 plaintiff attorneys (or 75 percent of those interviewed) are shown in Table III-21. This table shows two categories of answers which identify whether or not the referral fee is qualified by the extent of work by the prior attorney. The figures in the table show that the percentage of the contingent fee paid to the referring attorney is generally the same regardless of the extent of work done by the referring attorney. It can be concluded that the overwhelmingly frequent customary fee for referral of a case is one-third of the amount recovered by the attorney to whom the case is referred.

TABLE III-21.
PERCENT FEE TO REFERRING ATTORNEY*

Response Statistic	Response Not Qualified by Extent of Work	Response Qualified by Extent of Work
Mean	33 %	29 %
Median	33-1/3%	33-1/3%
Mode	33-1/3%	33-1/3%

*Based on responses by 60 plaintiff attorneys, or 75 percent of 80 plaintiff attorneys interviewed.

Five percent of the respondents indicated that they gave no fee to the referring attorney.

C. CASE HANDLING BEHAVIOR

Except for the information on docket delay, all of the results in subsections 1 through 5 are based on completed malpractice cases reported by lawyers in our surveys. In this subsection the dynamics of case handling are quantitatively described and discussed including case duration, win rates for plaintiff and defendant, mode of final outcome (settled, tried, abandoned), appeal percentages, recovery amounts and relationship of recovery to severity of injury and type of defendant. In addition, subsections 6 through 8 present and discuss the results of additional questions asked in the personal interviews with lawyers. These discussion topics include medical advice and expert witnesses, impediments to settlement, judge's influence and jury selection, influence and understanding of issues.

Case Duration and Docket Delay

Case duration is the time from case acceptance until the case is closed (i.e., until fixing of the sum certain, even if zero). Docket delay is the period of time in a particular jurisdiction from the filing of a case until it can be brought to trial. Since both of the surveys show that most medical malpractice cases are settled (about 65 percent) rather than tried, it might be expected that case duration should be considerably shorter than docket delay. However, our personal interviews revealed that settled cases were usually settled just before the day of the trial. Therefore the results shown in Figure III-1 are not surprising. This figure shows that the cumulative distribution for case duration and docket delay are very close.

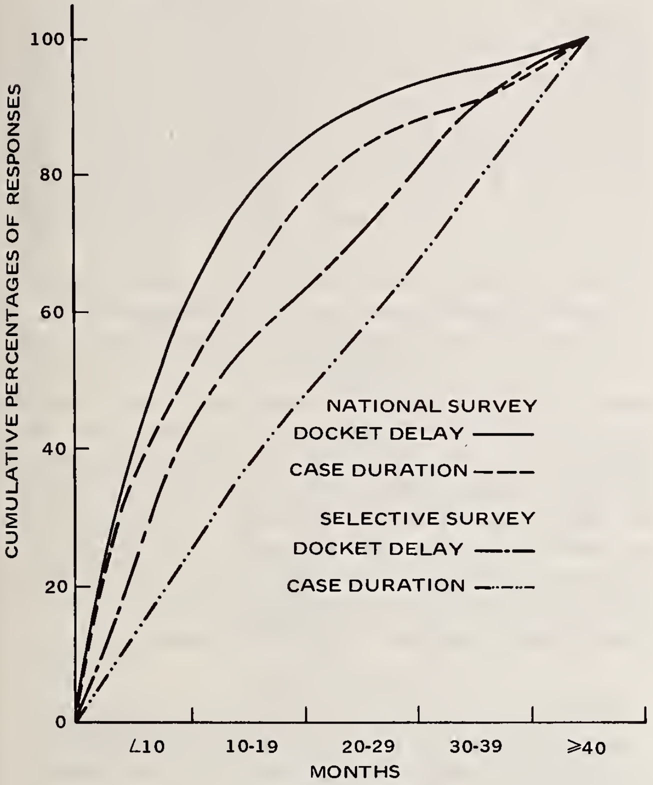


FIGURE III-1
CASE DURATION AND DOCKET DELAY

The upper pair of curves is based on the National Survey of 38 lawyers reporting docket delay and the 71 cases reporting case duration.

The lower pair of curves in Figure III-1 is based on 163 "known malpractice lawyers" and 478 cases from the Selective Survey. Once again, case duration is a little less than docket delay. The longer case duration for these known malpractice lawyers is explained, at least in part, by the fact that "known malpractice lawyers" tend to be found in metropolitan jurisdictions which are believed to have longer docket delays. Average delay values from the two surveys shown in Table III-22 illustrate this fact.

TABLE III-22.
AVERAGE DOCKET DELAY AND CASE DURATION

	Docket Delay (months)		Case Duration (months)	
	Mean	Median	Mean	Median
National	15	13	19	15
Selective Survey	21	18	28	27

Case Duration Trends

By examining data separately for the three years in our study time frame it is possible to check for trends in recent years. Results from the national survey of lawyers in Table III-23 below, show that average case duration has remained nearly constant in recent years.

TABLE III-23.
RECENT TREND IN CASE DURATION

	Mean Case Duration (months)	
	National Survey	Selective Survey
1970	20	30
1971	18	26
1972	22	27
Entire study period	19	28

Final Disposition

Settled, Tried, Abandoned

Both surveys show that most cases end up being settled (about 65 percent) as indicated by the figures below. Only about 17 to 29 percent of the cases are ever tried. These figures are based on counting each "case defendant" as a separate case, since half the time there are two or more defendants. In Table III-24, the sample consists of 92 case defendants from the National Survey and 883 from the Selective Survey.

TABLE III-24.
FINAL DISPOSITION OF CASES

	Percent of Cases	
Final Disposition	National Survey	Selective Survey
Settled	66	64
Tried	17	29
Abandoned	11	5
Other	6	2
Total	100%	100%

The "other" category was not always explained by respondents but included such comments as "defendant dismissed by judge." Note that the "Tried" percentages represent cases *terminated* by trial. For example, a case tried and then settled for an amount different from the jury award would not be classified as "Tried" for its final disposition.

Point of Settlement

The stage of proceedings at which cases are settled is shown in Table III-25 below. Only cases that were settled are shown.

TABLE III-25.
POINT OF SETTLEMENT

Stage of Proceedings when settled	Percent of Settled Cases	
	National Survey	Selective Survey
Before suit filed	24	5
Before trial	68	70
During trial	8	18
After trial	0	7
Total	100%	100%

Discussions with lawyers during the personal interviews suggest that the vast majority of cases settled before trial are settled "just before" the trial. As a result, much of the expense of preparing for the trial has been incurred even though the trial was never conducted. Those cases settled "after trial" represent settlements for an amount different from jury award. However, there is too little data in this category to warrant separate analysis.

When the figures in Table III-25 above were analyzed separately by plaintiff and defense lawyer, they showed virtually the same distribution which should be expected since a representative sampling of lawyers was obtained.

Appeals

An examination of the 21 case-defendants tried as reported in the National Survey shows that 29 percent of the trial outcomes were appealed. Although this survey is projectable to the U.S., the small sample size of only 21 trials makes the estimated percent subject to the reasonably large sampling error. (In other words, it is 90 percent certain that the true percent of tried cases, that are appealed, is between 13 percent and 46 percent.) However, results from the Selective Survey tend to support the nationally estimated appeal rate as shown in Table III-26 below. The Selective Survey appeal rate of 23 percent is accurate to ± 4 percent at the 90 percent confidence level because of the larger sample size.

TABLE III-26.
APPEAL RATES

	National Survey	Selective Survey
Sample Size (number of case defendants tried)	21	334
Percent Appealed	29%	23%

When these appeal rates are computed separately for plaintiff and defendant attorneys the differences between plaintiff and defendant reported appeal rates are not statistically significant at the 90 percent confidence level.

Plaintiff-Defendant Recovery Rates

The National Survey shows that in 68 percent of cases, some dollar amount was recovered by the plaintiff. Similarly the Selective Survey shows 79 percent of cases terminated favorably to plaintiffs. This includes all cases whether terminated by trial or settlement. Abandoned cases were cited as favorable defendant outcomes. There is some concern that the 68 percent plaintiff recovery rate might be biased upward. Lawyers interviewed in this study were asked to report on their most recent medical malpractice cases. Although up to five cases were requested, very few lawyers reported as many as five and the case load statistics in subsection B.2.a. suggest that very few lawyers had as many as five malpractice cases in the study time frame. A concern expressed by our interviewers (who were also attorneys) was that respondent lawyers (both plaintiff and defense) may have had a tendency to report their "winners" and may not necessarily comply with the request to give their "most recent" cases. Thus, there may be some reporting bias in the response which tends to inflate the plaintiff recovery rate above its true value since most lawyers were plaintiff lawyers. This in turn could explain the lower plaintiff recovery rate in the National Survey which had only 67 percent plaintiff cases versus 73 percent plaintiff cases in the Selective Survey mix. The amount of such bias, if indeed it exists at all, cannot be computed exactly. However, assuming that cases won by the plaintiff tend to be over reported by plaintiff attorneys and under reported by defense attorneys; it is felt that the differences between recovery rates reported by plaintiffs versus defendants provide rough bounds on this bias. Such a comparison is presented in Table III-27 below.

TABLE III-27.
PERCENT OF CASES FAVORABLE TO PLAINTIFF AS REPORTED BY DEFENSE VERSUS PLAINTIFF LAWYERS (SAMPLE SIZE SHOWN IN PARENTHESES)

Survey	Plaintiff Wins Reported By	
	Plaintiff Lawyer	Defendant Lawyer
National Survey	80% (59)	46% (26)
Selective Survey	84% (614)	62% (254)

It is important to note that all settlements are counted as favorable to the plaintiff even though the amount that he recovers may be substantially less than what he asked. Some of these settlements are undoubtedly viewed as victories by the defendant—but they are nonetheless counted as plaintiff recoveries and therefore outcomes favorable to the plaintiff in this study, since we have no objective way to distinguish such cases from the available data. However, by examining plaintiff win rate for trial cases only, settled cases can be eliminated. When this is done the percent of cases won by the plaintiff is reduced from 79 to 63 percent in the Selective Survey based on 333 trial case defendants. The National Survey provides a sample of only 23 trial case defendents so that the estimated 44 percent plaintiff win rate for trial cases in the National Survey is not very reliable. However, the effect is still clearly a decrease from the 68 percent won by plaintiff over all cases in the National Survey. Both surveys show a statistically significant decrease in plaintiff win rate for tried cases versus all cases. This is attributed, at least in part, to the existence of nuisance settlements and compromise settlements that may be a victory for the defendant in a practical sense but are counted among plaintiff victories when all cases are analyzed together.

A further investigation of the extent to which plaintiff recovery rate is influenced by severity of injury or type of defendant was conducted using data from the Selective Survey. The results shown in Table III-28 show relatively little influence of these factors on plaintiff recovery rate. Of the 532 defendant outcomes tabulated, only nine were categorized with an injury severity of "none" and these are therefore omitted in the table.

TABLE III-28.
PERCENT OF CASES FAVORABLE TO PLAINTIFF AS A FUNCTION OF SEVERITY OF INJURY AND DEFENDANT TYPE (SAMPLE SIZE SHOWN IN PARENTHESES)

	Severity of Injury		
Defendant Type	Minor	Death	Major
Physician	96% (51)	76% (49)	89% (19)
Surgeon	83 (109)	85 (55)	78 (49)
Hospital	84 (58)	97 (30)	84 (31)
Osteopath	*	*	*
All Others	77 (30)	75 (12)	75 (16)

*Insufficient sample size for reliable estimate.

Amount of Recovery

Components of Recovery

Data were collected on gross dollar recovery for each reported case. Additional cost breakdowns were reported for case expense, lawyer's fee, client recovery including medical bills and other. The sample size varied on an item by item basis due to nonresponses. In the National Survey item sample sizes ranged from 243 to 471 cases. The mean value of recovery components are shown below in Table III-29. The mean has been calculated using all cases, even those with zero recovery. Because sample sizes varied for the different components, the means for the gross recovery are not exactly equal to the sum of the means for the components.

The above statistics included case information reported by both plaintiff and defendant lawyers. These statistics clearly demonstrate a tendency to "bigger cases" (i.e., higher recovery) by lawyers in the Selective Survey. This is not surprising since this survey was of "known" malpractice lawyers which might naturally tend to include lawyers who handled cases with large recoveries. Furthermore, the Selective Survey included two cases with one million dollar recoveries and one case with $1.4 million recovery.

TABLE III-29.
COMPONENTS OF RECOVERY

	Average (mean) Recovery Amounts ($)	
	National Survey	Selective Survey
Gross Recovery	$22,000	$81,000
Case Expenses	400	2,000
Lawyer's Fee	5,800	20,000
Other	150	700
Client Recover (Including recovery for medical expenses)	7,200	35,700

Since the mean values shown above reflect the influence of some cases which have very large recovery amounts, medians have also been computed. The median gross recovery is only $3,500 in the National Survey and $25,000 in the Selective Survey. Even if attention is restricted to cases with non-zero recovery, the median gross recoveries only increase to $13,000 and $35,000, respectively.

A comparison of plaintiff and defendant lawyers shows substantially smaller "recovery", "fee", and "net to plaintiff" reported by defendant lawyers in the National Survey. However, the Selective Survey, based on a much larger sample, shows gross recovery somewhat larger among defendant lawyers reporting. The reader may also notice that in the National Survey, the sum of average component costs is considerably less than the average gross recovery, which is attributed to larger recoveries among those cases which only reported gross recovery. The term "client recovery" was intended to mean client of the plaintiff lawyer. It is possible that some defendant lawyers misinterpreted this figure so that the last three rows of both Tables III-30 and III-31 below are suspect for defendant lawyer responses.

TABLE III-30.
AVERAGE DOLLAR AMOUNT REPORTED IN NATIONAL SURVEY BY LAWYER TYPE (SAMPLE SIZE SHOWN IN PARENTHESES)

	Plaintiff	Defendant
Gross Recovery	$28,000 (43)	$10,000 (21)
Case Expenses	400 (47)	400 (6)
Lawyer's Fee	6,400 (40)	1,800 (6)
Other	150 (34)	* (1)
Medical Bills	1,400 (39)	0 (14)
Client Recovery	8,200 (39)	800 (14)
Medical Bills and Client Recovery	9,600 (39)	800 (14)

*Only one case reported.

TABLE III-31.
AVERAGE DOLLAR AMOUNT REPORTED IN SELECTIVE SURVEY BY LAWYER TYPE (SAMPLE SIZE SHOWN IN PARENTHESES)

	Plaintiff	Defendant
Gross Recovery	$74,000 (344)	$98,423 (127)
Case Expenses	2,200 (313)	1,300 (66)
Lawyer's Fee	25,900 (284)	4,900 (103)
Other	800 (238)	0 (5)
Medical Bills	2,700 (299)	1,000 (86)
Client Recovery	41,000 (291)	1,600 (69)
Medical Bills and Client Recovery	43,700 (299)	2,600 (86)

Recovery by Severity of Injury and Defendant Type

The amount of recovery has been analyzed as a function of severity of injury and as a function of defendant type to determine the extent to which these two variables might account for variations in dollar recovery. It would seem reasonable to expect that more serious injuries give rise to higher recoveries. It is also possible that certain categories of defendants are more "hard-hit" in terms of recovery payouts than other categories of defendants. This could be explained by differences in the perceived ability of the defendant to pay (e.g., income of doctor versus nurse) or patient expectations which might be higher in some medical situations than others.

Severity of Injury and Amount of Recovery

The classification of minor versus major injury were made based on the description of the alleged injury:

minor: something was damaged but not removed (e.g., scarring, broken ankle)
major: amputated member or something removed from body or complete loss of sense organ (e.g., blindness)

Figure III-2—shows the influence of severity of injury. These results show that:

(a) "major injuries" give rise to higher recovery than death
(b) death and "minor injuries" give rise to about the same order of magnitude of dollar recovery
(c) multiple defendant cases usually result in higher dollar recovery than single defendant cases (multiple defendant cases show more than twice the recovery for major injuries)
(d) the Selective Survey produces consistently higher recoveries (by a factor of two or a little more) than the National Survey for a given severity category.

Type of Defendant and Amount of Recovery

The influence of defendant type on recovery seems to be negligible based on results from the Selective Survey. Only data from the Selective Survey is presented here because the National Survey provided too small a sample to allow this further stratification of results. In order to meaningfully compare the influence of defendant types it is necessary first to group the data by severity categories as

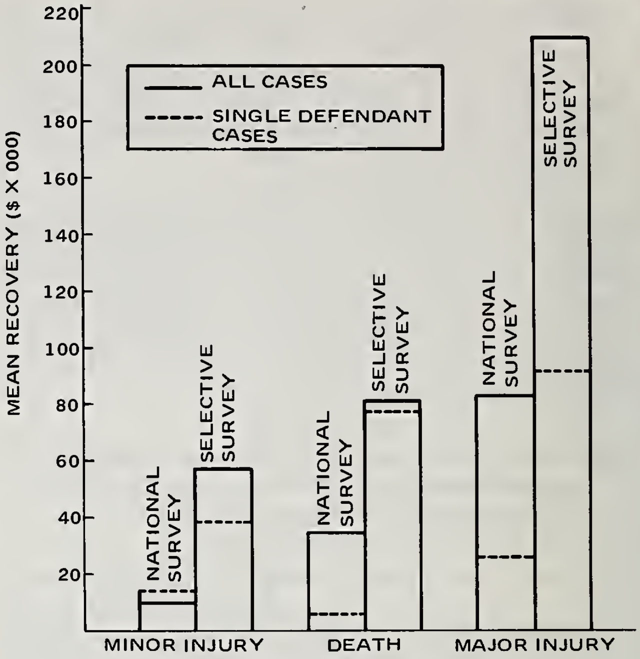


FIGURE III-2
AVERAGE RECOVERY AMOUNT PER CASE AS A FUNCTION OF SEVERITY OF INJURY (DATA FROM SELECTIVE SURVEY)

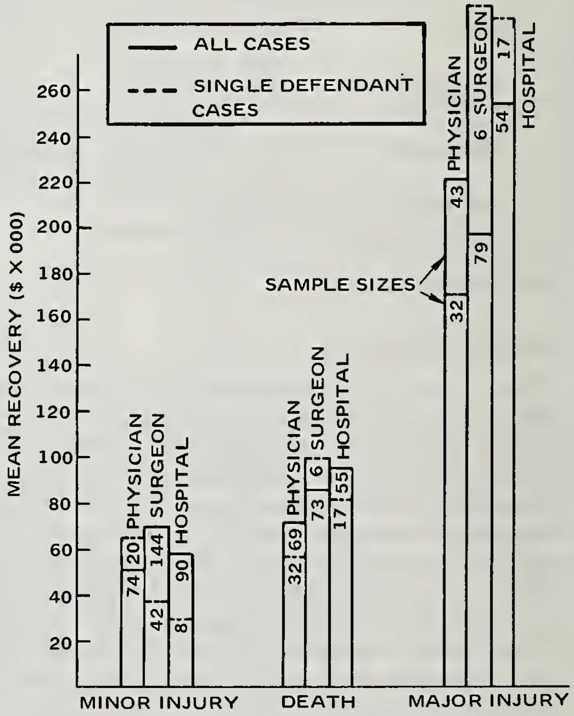


FIGURE III-3. AVERAGE RECOVERY AMOUNT PER CASE AS A FUNCTION OF DEFENDANT TYPE FOR THREE DEGREES OF INJURY SEVERITY

has been done in Figure III-2. In multiple defendant cases, the recovery amount recorded is the total case recovery, not the partition of the recovery that comes from a single defendant. As a result, the influence of defendant type might be more purely analyzed by examining single defendant cases only (see dashed lines in Figure III-2). However, examining either multiple or single defendant cases (i.e., either the dashed or solid lines in Figure III-3) leads to the same general conclusion—that defendant type has relatively little observable influence on recovery.

It is possible that a finer classification of defendant types—e.g., not just "surgeon" but "plastic surgeon", "neurosurgeon", etc. might expose more significant differences in average recovery amounts. However, these finer classifications were not generally available in our data and small sample sizes resulting from a much finer level of classification would have led to unacceptably low precision in the estimates of average recovery.

Amount of Recovery as a Function of Lawyer Hours on Case

The question has occasionally been raised as to whether or not there is any relationship between the effort expended by the plaintiff lawyer and the amount of recovery obtained. Figure III-4, based on plaintiff lawyers in the Selective Survey, shows a clear relationship with roughly 100 lawyer hours expended for every $25,000 recovery on the average. Figure III-4 is only a rough plot of the data. The end intervals were actually tabulated as under 50 hours and 1,000 hours more. This plus the use of interval midpoints makes this figure only a rough but instructive plot of increasing recovery with lawyer hours.

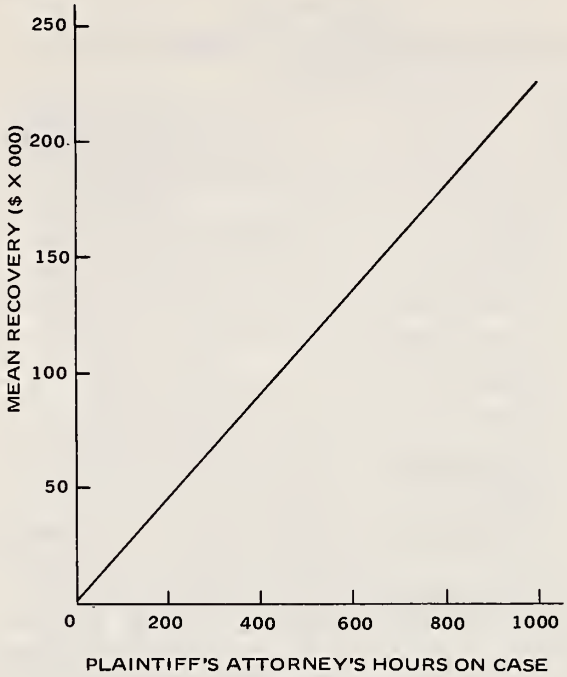


FIGURE III-4
AVERAGE RECOVERY AMOUNT VERSUS
PLAINTIFF LAWYER HOURS ON CASE
(DATA FROM SELECTIVE SURVEY)

Sources of Medical Advice and Expert Witnesses

Attorneys personally interviewed were asked the lead question "How do you get medical advice and expert witnesses?". Their responses to this question are grouped and categorized in Table III-32. The information is shown for all respondents and broken down by plaintiff and defense representation. In addition, the table presents the responses in their rank order frequency of the total.

Analysis of Reported Relative Importance of Sources of Medical Advice and Expert Witnesses

The responses to the lead question often indicated that there were two distinct steps in obtaining medical advice. The first step was the attorneys' need for medical advice determining whether to accept the case. This advice ordinarily comes from physicians in the immediate community. The second step was the need for expert testimony, which usually is obtained from doctors outside the immediate community.

More than half of the respondents stated that their source of medical advice and expert witnesses was obtained from physicians in return for a fee. The percentage frequency of this response was twice as great for plaintiff attorneys as for defense attorneys. However, when the category of the insurance-retained experts (shown in rank order frequency as ninth in total importance) is added to the defense response, the answers are approximately the same. About half of the respondents mentioned that their medical advice came from physician "friends". A slightly higher percentage of plaintiffs' attorneys characterized their sources as "friends" than did defense respondents but a high percentage of defense attorneys so characterized their sources.

Third in order of total importance, medical libraries, indicates that a significant proportion of attorneys for both the plaintiff and defense feel they require an independent knowledge and understanding of the medical facts through their own research. One-fourth of the defense attorneys mentioned medical libraries, while one-third of the plaintiffs' attorneys did so.

Fourth in total order of importance was an approach to renowned experts in the field of medicine in which the claim arose. Only a slightly higher percentage of defense attorneys indicated this source for expert advice.

Fifth in order of importance were local medical societies. Although one-tenth of the plaintiffs' attorneys mentioned this source was available to them, fully three times the percentage of defense attorneys indicated it as a productive source. This suggests clearly that the cooperation of organized medicine is far more highly oriented toward defending its members than in providing information to all who seek it in the determination of the merits of a medical malpractice claim.

Frequently mentioned by members of the plaintiffs' bar was the fact that some physicians had formerly been witnesses in other personal injury cases or in medical malpractice cases. More than three times as many plain-

TABLE III-32
SOURCES OF MEDICAL ADVICE AND EXPERT WITNESSES

Rank Order	Source	Percent of Attorneys Responding*		
		Total N = 105	Plaintiff N = 80	Defense N = 25
1	Purchase opinions from physicians	56	63	36
2	Physician friends	50	53	40
3	Medical libraries	26	33	24
4	Approach renowned experts	12	11	16
5	Local medical societies	12	9	28
6	Former witnesses who are physicians	10	13	4
7	Medical school faculty or staff	10	8	20
8	Subsequent treating physician	9	9	8
9	Insurance company retained experts	6	0	24
10	Coroner	2	3	0
11	Physician in immediate family or related	2	3	0
12	Other	6	13	0

*Based on responses of 105 or 96 percent of 109 lawyers interviewed.

tiffs' attorneys as defense attorneys mentioned these physician witnesses as an important source of medical advice or testimony. It should be noted, however, than many plaintiff attorneys in discussing these witnesses indicated that they would prefer not to use physicians who frequently acted as witnesses. Most had never used them or did so only in rare cases because of the negative impact of using a physician who regularly testifies against his own "brother physicians" and may thereby be viewed as a renegade.

Seventh in order of importance were faculty or staff members in educational institutions. Although mentioned by a significant number of plaintiffs' attorneys, more than twice the percentage of defense attorneys apparently consider this source of information important. This is a surprising finding, for literature directed to plaintiffs' attorneys frequently suggests this source, characterizing it as unimpeachable and, in general, above the social and peer pressures that would make it difficult for a practicing member of the medical community to testify or give an opinion adverse to his workaday world colleagues.

It is frequently stated in the literature that the subsequent treating physician, who perhaps may first make a claimant aware that his former physician has committed a breach of medical duty, is a major source of medical malpractice claims. While this assertion may be true, the importance of the subsequent treating physician as a source of medical advice or expert testimony is diminished by the information shown in the table. Interview responses as they are tabulated indicate that fewer than 10 percent of either plaintiff or defense attorneys responded that the subsequent treating physician was a source of information.

Not surprisingly, about one-fourth of the defense respondents indicated that their medical advice and expert witnesses were provided by the professional liability insurance carrier for the defendant physician.

The local coroner is a physician in the community who is presumably free of peer pressure from local medical organizations. He should therefore be a productive source of expertise to a claimant, and one whose expert opinion is recognized by the court and jury. Surprisingly, only three percent of the plaintiffs' attorneys mentioned this source. No attorney primarily engaged in representation of defendants was reported to rely on the local coroner for expert advice or to give testimony.

Three percent of the plaintiffs' attorneys likewise mentioned the existence of a physician in the immediate or closely related family while no defense attorney so responded.

Responses characterized as "other" (and last in frequency of importance in the table) were a collected group of responses from plaintiffs' attorneys indicating: (a) various sources such as commercial medical-legal consulting organizations, (b) frustration in attempting to secure expertise, (c) self-reliance, (d) publications or formal listings such as the American Medical Association *Citation* and (e) listings available through the American Trial Lawyers Association.

Conclusions About Medical Advice and Expert Testimony

It is concluded from this examination that the spectrum of sources of medical advice and expert witnesses available to attorneys seeking to determine the truth and merits of a medical malpractice are widely divergent. Defense attorneys overwhelmingly have the advantage through opinions purchased by themselves or from experts retained by the insurance carrier whom they represent. Friendship of physicians was important to both plaintiff and defense attorneys, but slightly more important to plaintiffs' attorneys. Both groups indicated a significant concern for self preparation in medical library research.

The "Locality Rule" and Expert Witnesses

During the personal interviews, it was attempted to determine whether the existence of the "locality rule" (see definition, page 124) in a particular jurisdiction changed or influenced the behavior of plaintiff and defense attorneys in seeking out expert advice and witnesses. In general, the interviewer sought to examine whether those jurisdictions applying a strict locality rule (the standard of care against which the defendant's breach of duty or departure from the standard is measured must be elicited from a medical practitioner in the immediate community) differed from those jurisdictions where there was a more liberalized locality rule (permitting experts to appear from other jurisdictions and testify as to the reasonable standard of care within a larger "community" or in a more substantial departure from the old rule admit evidence of a uniform national practice to establish the standard of care). Results of the personal interview show that lawyers often were unaware of the existence of the locality rule in their jurisdiction. This may be explained by the fact that the personal interviews were conducted only in major metropolitan areas where the locality rule has little influence even if it does exist. Therefore, our study does not allow us to assess the influence of the locality rule in the more rural parts of the United States where its impact is presumably greatest.

Impediments to Settlement

During the interviews of selected lawyers, several major areas were explored to determine why medical malpractice claims seemingly require so long to settle. Three general areas of inquiry were directed to the question of claim settlement: the major impediments to pretrial settlement in the jurisdiction, whether insurance companies refuse reasonably to negotiate prior to the filing of a lawsuit, and the manner in which an attorney makes his decision on the dollar amount to base a demand or settlement offer.

Major Reported Settlement Impediments

The major reasons given in response to the lead question "What are the major impediments to pretrial settlement in this jurisdiction?" are listed in Table III-33. Response categories are listed in the rank order frequency of total responses. At the bottom of the table is shown the small percentage of respondents who indicated an observation that there was no impediment to settlement in the particular jurisdiction. Less than five percent of the total responses could be grouped into this category, and although the percentage response for defendant attorneys is almost twice as high as the percentage given by those representing plaintiffs, the numbers so responding are too small to make a significant statistical difference. The only conclusion that can be reached is that only about five percent of the respondents suggested that there were no settlement impediments in their jurisdiction.

First in rank order importance was the unique provisions in physicians' professional liability insurance which requires that before settlement can be made by the insurance carrier, the physician has the right to approve such action. Almost half of the total respondents placed this as the major settlement impediment. Not surprisingly, almost two and one-half times the percentage of plaintiff responses were in this category as were responses by attorneys representing defendants. The second major reason articulated by the composite plaintiff and defense bar respondents was a tendency on the part of insurance companies to wait until the last moment before going to trial to make a settlement offer. As might be expected, almost nine times as many plaintiff attorneys as defendant attorneys made this response.

About 10 percent of the attorneys indicated that lack of lawyer preparation was a causal factor in failure to reach settlement. The small numbers make the percentage distinction between plaintiff and defense responses statistically insignificant. Two responses can be related to problems in the administrative cogs of the wheels of justice: the long wait to trial and ineffective pretrial practices. Seven percent of the plaintiff and defense responses and of the total responded that the long wait to trial acted as an impediment to settlement. Only three percent of the attorneys interviewed, all of whom were members of the plaintiffs' bar, indicated that ineffective pretrial in their jurisdiction acted to impede settlement.

TABLE III-33
MAJOR IMPEDIMENTS TO SETTLEMENT

Rank Order	Impediment	Percent of Attorneys Responding*		
		Total N = 102	Plaintiff N = 75	Defense N = 27
1	Defendants' Right to Refuse Settlement	49	47	19
2	"Last Minute" Settlement Attitude of Insurance Companies	26	35	4
3	Lack of Lawyer Preparation	10	11	7
4	Long Wait to Trial	7	7	7
5	Wait for Damages to Become Certain	4	4	4
6	Plaintiff Wants Jury Trial	3	0	11
7	Demand Unreasonably High	3	0	11
8	Ineffective Pretrial	3	4	0
	No Impediment to Settlement	5	4	7

*Based on 102 or 94 percent of 109 attorneys interviewed giving some response.

There was agreement in the fifth ranked order impediment, that the delay was a result of either one or both sides waiting for damages to become certain. Four percent of the total plaintiff and defense attorneys so responded.

Ranked in sixth and seventh order overall (due to the dominant number of plaintiff attorneys in the sample of respondents) were 11 percent of the defense attorneys who responded with an assertion that settlement was impeded by the plaintiff's desire for a jury trial or was the result of an unreasonably high demand.

What can be concluded from this array of beliefs to plaintiff and defense attorneys is that both groups agree overwhelmingly that the defendant's right to refuse settlement is the single most dominant factor in impeding the settlement of medical malpractice claims. In contrast to this agreement, the plaintiff and defense attorneys differed most sharply as to the attitude of the insurance companies in reasonably seeking settlement. Finally, the defense attorneys expressed a view, by slightly more than one tenth of those responding, that settlement was impeded by either a desire for trial on the part of the plaintiff (and hence an unwillingness even to consider settlement) or an unwillingness to consider settlement on reasonable terms.

Insurance Company Settlement Practices

The second overall major impediment to settlement identified in the preceding analysis, the so-called "last ditch" attitude of insurance companies to negotiate reasonably, was explored through the lead question: "Why do insurance companies refuse to negotiate?" That question was asked of all respondents who indicated it a specific impediment (26 percent). Useful responses were obtained only from plaintiff attorneys and are arrayed in their rank order frequency of mention in Table III-34. Percentages are computed on the base of the number of lawyers giving some answer which was critical of insurance company practices.

The most dominant response (about one-third) indicated that insurance companies are economically motivated in

TABLE III-34.
REPORTED INSURANCE COMPANY PRACTICES IMPEDING SETTLEMENT

Reported Practice	Percent of Plaintiff Attorneys Responding (N = 21)
Economic Incentive Versus Judgment Interest	33%
Defense Attorneys' Hourly Fee	30%
Good Historical Win Record	20%
Wait To See if Plaintiff Obtains Credible Expert	13%
Unwillingness To Disclose Defense Expert Identity or Opinions	4%
Total	100%

their failure to reasonably reach settlement. The argument advanced is that earnings on invested premiums are so large in relation to judgment interest that settlement drags interminably.

This issue of failure of the defense to pursue litigation fairly and ethically was also of noteworthy mention by those plaintiffs' attorneys critical of insurance comanies in their assignment of the defense attorneys' hourly fee as an important (30 percent) inhibition to settlement. The language of respondents was sharp and critical in this regard; e.g., "filing phony motions" and "bringing frivolous appeals". Whether or not these assertions are true cannot be determined, of course, for the credibility upon which a motion or appeal is based relates to the motivation in making it. This is analogous to the problem raised by spokesmen for the defense bar and insurance industry—the so-called "frivolous claim". The results are reported here for the use of future researchers and those who aim to clarify the level of professional understanding between the plaintiff and defense bar.

Third in total importance (20 percent) was the expression by plaintiff attorneys critical of insurance companies that the good historical defense win record was sufficient of itself to cause insurance companies to be loath to settle.

Discovery of the plaintiff and defense expert witness trial posture accounted for the fourth and fifth items of relative importance.

Influence of the Trial Process on the Outcome of Medical Malpractice Claims

Two general areas of inquiry were explored during the interviews of selected attorneys concerning the pretrial and trial process: (a) jury understanding of the complex medical issues and questions of law, and (b) trial judge influences on the outcome of medical malpractice trials.

Reported Scope and Limitations of Jury Understanding

In this section, answers to the two lead questions "Do juries understand the medical issues?" and "Do juries understand the court's instructions on law?" are analyzed. The analysis is based on only those attorneys who answered both questions. In general, the response rate for attorneys answering only one question differed only slightly from that of attorneys answering both. This slightly differing response rate for the attorneys interviewed is shown in Table III-35.

TABLE III-35.
RESPONSE RATE TO JURY UNDERSTANDING LEAD QUESTIONS

Question	Percent of Responses	
	Plaintiff Attorneys N = 80	Defense Attorneys N = 29
Do Juries Understand the Medical Issues?	94	97
Do Juries Understand the Court's Instructions of Law?	91	97

The results for those attorneys responding to both lead questions, are shown in Table III-36. The columns of the table show whether the jury understood medicine or law, as reported by the plaintiff and defense attorneys. Both number and percentage of responses are shown. The first column of the table indicates those respondents who believe that there was no limitation on the understanding of the jury, i.e., that both "medicine and law" were understood. The remaining columns of the table indicate a belief on the part of the respondent that the jury has difficulty understanding either law or medicine, or both. The final column of the table totals all responses contained in the table.

It can be concluded from Table III-36 that the majority of respondents believe that juries understand both medical and legal issues presented in a medical malpractice trial. What is remarkable, however, is that this belief is not shared with equal vigor by plaintiff and defense attorneys, with 59 percent and 79 percent respectively. Combining portions of Table III-36 show that 91 percent of the responding lawyers believe juries understand the medical issues and 65 percent believe juries understand the legal issues.

It should be noted that medical issues represent almost the entire subject of trial, and can be explained to a jury in chart form or other graphic presentation method. Legal issues are usually explained in a prepared charge by a judge at the end of a trial. It should also be noted that although the lead questions were asked regarding medical malpractice cases, many lawyers appeared to the interviewers to respond on the basis of their total practice which usually involved automobile injury cases, invoking the often misunderstood (or avoided) issue of contributory negligence. Lastly, it should be noted that many attorneys

TABLE III-36.

REPORTED SCOPE AND LIMITATION ON JURY UNDERSTANDING OF MEDICINE AND LAW

Class Respondent Reporting	Reported Jury Understanding									
	Medicine and Law		Medicine but Not Law		Not Medicine but Law		No Medicine and Not Law		Total	
	N	Per-cent	N	Per-cent	N	Per-cent	N	Per-cent	N	Per-cent
Plaintiff Attorneys	42	59	21	30	0	0	8	11	71	100
Defense Attorneys	22	79	5	18	0	0	1	4	28	100
Total	64	65	26	26	0	0	9	9	99	100
	No Limitations on Understanding		Limitations on Understanding							

were reluctant to respond to this question in other than a speculative vein, since none of those interviewed would seriously suggest that they really know and understand what is in the mind of the typical juror.

It is concluded from the foregoing analysis that the vast majority of both plaintiff and defendant attorneys have a high regard for the ability of the American jury to understand complex issues of medicine and law in the trial of a medical malpractice case. The attorneys' beliefs as to the jurors' lesser ability to understand the law is a frequently articulated criticism of the trial process as it traditionally is practiced. It is significant to note that no respondent indicated that jurors understood the law but did not understand the medical issues in a malpractice trial.

Factors That Influence Jurors in Medical Malpractice Cases

Respondents in the personal interviews were asked the lead question, "What factors influence the jury in malpractice cases?"

The responses of this group of attorneys familiar with the trial of medical malpractice cases were categorized into four major areas of analysis. As with preceding tabulations of responses, multiple responses were allowed in the rules for coding which produce cumulative percentages well over 100 percent. Responses to the question categorized by the four major areas of analysis are shown in Table III-37.

Trial presentation was the factor most frequently mentioned, with about 80 percent of the plaintiff attorneys and almost all of the defense attorneys (96 percent) answering within this topical framework. Almost three-quarters of the respondents indicated that facts unique to the particular case at trial were major influential factors on jurors. There was little difference in the response to this question when characterized in the aggregate between the plaintiff and defense attorneys. Although, as will be later described, the underlying factors in their beliefs differ significantly.

Almost 40 percent of the respondents mentioned some factor influencing jurors which could be characterized as prejudice or bias. The plaintiff respondents mentioned this factor with twice the frequency of attorneys representing defendants. About 12 percent of the total responses fell into the "other" category, which will be subsequently discussed.

TABLE III-37.
MAJOR FACTORS THAT INFLUENCE JURORS

Major Factor Influencing Juror	Percent of Responding Attorneys*		
	Total N = 97	Plaintiff N = 70	Defense N = 27
Trial Presentation	84	79	96
Facts Unique to Case	71	71	74
Prejudices and Biases	37	44	19
Other	12	9	22

*Based on responses of 97 lawyers, or 89 percent of 109 interviewed.

Trial Presentation Effectiveness Factors

The trial presentation factors mentioned by respondents are characterized into three classifications shown in Table III-38.

All of the factors that deal with attributes of trial presentation are subject to only limited control by the attorney. Mentioned twice as frequently as other factors, by both plaintiff and defense attorneys, was the attitude and demeanor of the physician defendant. A slightly higher percentage of defense attorneys mentioned the attitude and demeanor of both the plaintiff and defendant—about one and a half times as frequently as did attorneys for the plaintiff.

Plaintiff attorneys mentioned the stature and clarity of expert witnesses twice as frequently as the defense attorneys (21 percent versus 11 percent). This differing attitude between plaintiff and defense attorneys about the

TABLE III-38.
FACTORS DEALING WITH EFFECTIVENESS OF TRIAL PRESENTATION

Trial Presentation Factor	Percent of Responding Attorneys*		
	Total N = 97	Plaintiff N= 70	Defense N = 27
Attitude and Demeanor of Physician Defendant	43	39	56
Attitude and Demeanor of Plaintiff	22	19	30
Stature and Clarity of Expert Witnesses	19	21	11

*Based on responses of 97 lawyers, or 89 percent of 109 interviewed.

importance of articulate expert testimony is consistent with the higher percentages of defense attorneys who believe that juries have no trouble understanding issues of medicine and law as shown in Table III-36.

Major Factors Unique to the Medical Malpractice Case

As noted in the preceding section, over 70 percent of both plaintiff and defense attorneys believe that major factors influencing jurors stem from facts unique to the particular case at trial. Table III-39 characterizes these case-unique factors in their percentage frequency mentioned by interview respondents.

TABLE III-39.
FACTORS DEALING WITH FACTS UNIQUE TO CASE THAT INFLUENCE JURORS

Case-Unique Factor	Percent of Responding Attorneys*		
	Total N = 97	Plaintiff N = 70	Defense N = 27
"Horror" Factor, or Demonstrability of Injury	37	34	44
Evidence of Record Falsification	24	24	22
Prior Doctor-Patient Relationship	6	7	4
Particular Hospital or Physician	4	4	4

*Based on responses of 97 lawyers, or 89 percent of 109 interviewed.

Most frequently mentioned was the specific injury involved in the case, with more than one-third of both plaintiff and defense attorneys mentioning the "horror" factor, or the demonstrability of the injury, as an important factor influencing jurors. The defense attorneys mentioned the factor slightly more frequently than did plaintiff attorneys on a percentage basis.

Surprisingly, about one-fourth of plaintiff and defense attorneys both mentioned that evidence of record alteration had a significant influence on jurors. What is surprising is not that record alteration influenced jurors, but that it was mentioned with sufficient frequency as to suggest it is not a rare practice among defendants accused of an act of medical malpractice. However, it is not valid to assume from the fact that 24 percent of lawyers mentioned record alteration as "a factor that influences a jury in a medical malpractice case" that record alteration occurs 24 percent of the time.

Prejudices and Biases of Jurors as Perceived by Attorneys

More than one-third of the total attorneys responding mentioned some factor which could be characterized as a prejudice or bias of a juror in a medical malpractice trial. Table III-40 outlines those most frequently mentioned.

TABLE III-40.
FACTORS OF BIAS OR PREJUDICE INFLUENCING JURORS

Factor	Percent of Responding Attorneys*		
	Total N = 97	Plaintiff N = 70	Defense N = 27
Bias for Physician	23	30	7
Bias Against Physician	6	4	11
Public Knowledge About Medicine	5	6	4
Concern With Insurance Rates	1	1	0

*Based on responses of 97 lawyers, or 89 percent of 109 interviewed.

Responses of greatest frequency and of most interest are those by attorneys who believe that jurors have a bias for physicians and by those attorneys who believe that jurors exhibit a bias against physicians. A bias of jurors in favor of physicians was mentioned by plaintiff attorneys over four times the percentage frequency as by defense attorneys.

The public's pre-existing knowledge about medicine was mentioned with about the same percentage of frequency by both plaintiff and defense attorneys (about five percent), and one respondent mentioned a belief that the public was influenced by its concern with insurance rates.

A conclusion that can be drawn from this examination of the beliefs of attorneys about the biases or prejudices influencing jurors is that the most important factor, from the perspective of plaintiff attorneys, is "biases for physicians."

Other Factors Influencing the Jury

Miscellaneous responses by plaintiff and defense attorneys included ethnic prejudices, the competence and demeanor of attorneys, and race as factors influencing the jury. Of these miscellaneous responses, only one was mentioned with a significant frequency—the competence and demeanor of the attorney (six percent). It is interesting to note that these attorneys, who in the mind of the layman apparently perform such a dominant role in the presentation of a case, so infrequently mentioned the factor of their own presence and participation.

Influence of the Court

Two issues were explored to determine whether trial judges affect the outcome of medical malpractice lawsuits through the following lead questions:

(1) "Do judges encourage pretrial settlement?"

(2) "How do judges influence the outcome of trials?"

"Yes/No" answers were tabulated and where an affirmative answer was given to the question about their influence, the reasons were categorized. Table III-41 presents the responses of lawyers giving their opinion as to pretrial settlement.

TABLE III-41.
RESPONSES TO THE QUESTION: "DO JUDGES ENCOURAGE PRETRIAL SETTLEMENT?"

Response	Percent of Responding Attorneys*		
	Total N = 104	Plaintiff N = 78	Defense N = 26
Yes	79	76	88
No	21	24	12
Percent Responding	98	98	93

*Based on responses by 98 percent of 106 lawyers interviewed.

It may be concluded from the table that the vast majority of lawyers believe that judges encourage pretrial settlement and that defense attorneys are somewhat more inclined to that viewpoint than are plaintiff attorneys. The most frequent term describing the actions of judges during the pretrial procedure was "persuasion" (mentioned by about one-fifth of both plaintiff and defense attorneys). A few plaintiff attorneys (only three percent) phrased it more strongly—"coercion".

During the trial, 10 percent of the plaintiff attorneys suggested that judges exhibit a pro-physician bias, while no attorney representing a defendant so responded. In describing methods which judges use to influence the trial outcome, the most frequently reported descriptor was "inflection" (about eight percent of both plaintiff and defense attorneys). Second in order was "admission of evidence".

D. CONTINGENT LEGAL FEE ANALYSIS

The contingent fee arrangement between a lawyer and his client provides a means by which a claimant can obtain legal counsel for little or no charge if he loses. If he wins, he pays his lawyer some fraction of the recovery amount. This fraction is usually between one-third and 40 percent and is sometimes a sliding percentage based on the stage of proceedings at the time of settlement (i.e., pretrial, trial, post trial, appeal). In the United States nearly all personal injury cases brought by claimants are handled under a contingent fee arrangement with the plaintiff lawyer. Defense lawyers, however, work almost entirely on an hourly fee basis. The contingent fee system is prohibited in Great Britain, although there is a difference of opinion among British lawyers concerning the desirability of this restriction ("The Malpractice Problem in Great Britain", *Infra*, p. 854ff.

The contingent fee system has been both praised and attacked. It has been praised by those who argue that it allows many claimants with legitimate, compensable injuries resulting from medical malpractice and other tort claims to obtain legal counsel which they could not otherwise afford. It also provides a financial incentive for a plaintiff lawyer to represent his client's best interests. The second aspect is sometimes expressed as a weakness of the contingent fee arrangement since it might encourage lawyers (a) to accept nonmeritorious claims if the potential recovery is high, and (b) to obtain unreasonably large payments for services at the expense of clients.

The frequency of different types of fee arrangements in medical malpractice cases is presented below. The influence of the contingent legal fee system is then evaluated in several ways. In evaluating the reasonableness of amounts earned by plaintiff lawyers under the contingent fee arrangement, we have no social and philosophical basis for determining the "worth" of the plaintiff lawyer services. Therefore, as one way to provide an objective basis of evaluation, we have calculated the "effective hourly fee" earned by plaintiff lawyers and compared this with the average hourly fee earned by defense attorneys who do not work on a contingent fee basis. The hourly fee includes overhead costs for the lawyer and his law office, so that the net fee to the lawyer can be much less than the specified fee. No data on overhead costs is available in our study. Nevertheless this method of evaluating the plaintiff lawyers "effective hourly fee" should allow us to determine whether or not the contingent fee provides an excessively high compensation to plaintiff lawyers.

The plaintiff lawyer is essentially faced with a gamble when he decides to accept a case, since he recovers nothing for his hours on the case if his client loses, but earns some fraction of the recovery (usually one-third) if his client wins. Therefore the effective fee averaged over all his cases (winners and losers) is a way of measuring his average payoff. The statistical distribution of plaintiff lawyer hours on those cases which his client loses is provided in order to measure the extent and frequency of uncompensated efforts.

In order to formally characterize the gamble that the lawyer is faced with, a simple mathematical model has been developed. This "Expected Payoff Model" characterizes the lawyer as a decision maker faced with a medical malpractice claim. The model describes the combinations of anticipated recovery amount, probability of winning, contingent fee rate, and co-counsel charges which would allow him to earn at least his normal hourly fee. Of courses lawyers do not actually go through this formal procedure when screening a potential case. In actual practice a plaintiff lawyer will not perform like a purely logical decision maker. In multidimensional problems such as this, humans seldom can weigh all factors accurately at once. Furthermore, many parameters that enter into the decision, such as probability of winning and amount of award, are rough estimates at best. In spite of these differences between the real world and the "Expected Payoff Model", the model does help explain lawyer case acceptance behavior. Specifically this model is examined to evaluate the economic motivation of a logical plaintiff lawyer to (a) accept nonmeritorious cases with potentially high recovery and (b) to reject meritorious cases if expected recovery is low.

Finally, personal interviews are analyzed to provide a summary of lawyers' opinions concerning the influence of the contingent fee system on the incidence and disposition of malpractice claims.

Fee Arrangements

Types of Legal Fee Arrangements

As expected by the attorneys on our project team prior to this study, nearly all plaintiff lawyers normally use a contingent fee arrangement with either a fixed or sliding percentage of the recovery as their fee. Lawyers in the National Survey reported a fixed contingent fee twice as often as a sliding contingent fee as shown in Table III-42. Even though the sample size is small, the observed difference between 30 and 60 percent is significant at the 95 percent confidence level. However, in the Selective Survey, these two fee arrangements were reported equally often.

TABLE III-42.
PERCENT OF LAWYERS WHO NORMALLY USE DIFFERENT TYPES OF FEE ARRANGEMENTS

Fee Arrangement	National Survey	Selective Survey
Fixed Contingent Fee	60	45
Sliding Contingent Fee	30	47
Hourly Rate	3	1
Other	7	7
Total	100%	100%
Number of Plaintiff Lawyers Reporting	30	132

Fixed Contingent Fee

Among those lawyers reporting the use of fixed contingent fee, a rate of 33-1/3 percent was most common although the mean was slightly higher, due to some rates at 40 percent and 50 percent as shown below the median turned out to be equal to the mean in this instance as shown at the bottom of Table III-43.

TABLE III-43.
CONTINGENT FEE PERCENTAGE RATES

Fixed Contingent Fee Percentage	Percent of Respondents With This Fee	
	National Survey	Selective Survey
25%	0	2
33-1/3%	78	58
40%	11	15
45%	0	5
50%	11	20
Total	100%	100%
Mean Fee	36%	38%
Median Fee	36%	38%
Number of Plaintiff Lawyers Reporting	18	60

Sliding Contingent Fee

Most of the sliding fee arrangements described by plaintiff lawyers were based on three stages of legal proceedings, i.e., before trial, through trial and through appeal. The percentages given most frequently were "33-1/3 percent before trial; 40 percent through trial and appeals." Other percentages ranging from 20 percent before trial to 50 percent through appeals are shown below in Table III-44. It should be noted that in many cases attorneys specified that the normal sliding contingent fees are reduced when the plaintiff is a minor or is deceased.

Another type of sliding contingent fee arrangement encountered in our survey only in New Jersey is based on amount of recovery. The "New Jersey sliding scale" permits the plaintiff lawyer to receive 50 percent of the first $1,000; 40 percent of the next $2,000; 33-1/3 percent of the next $47,000; 20 percent of the next $50,000 to $100,000; 10 percent over $100,000.

A complete listing of the sliding contingent fees from the survey are shown in Table III-44 with the frequency of their occurrence.

Defense Lawyer Hourly Fee

Based on 23 defense lawyers who reported hourly fee in the Selective Survey an average fee of about $50 per hour was reported as shown in Table III-45. Only five defense lawyers reported hourly fee in the National Survey which provides us with insufficient data to present a distribution. The hourly rates for these five ranged from $30 to $50. As mentioned earlier, these hourly rates include the overhead cost of the defense firm so that the lawyer receives less than these hourly rates in salary.

Effective Fee

In order to evaluate the common assertion that "the

TABLE III-44.
SLIDING CONTINGENT FEE ARRANGEMENTS

Sliding Contingent Fee Arrangement	Frequency of Occurrence National Survey	Frequency of Occurrence Selective Survey
20 to 25% before trial; 33-1/3 through trial	2	1
25% before trial; 33-1/3 through trial; 40% through appeals	1	4
33-1/3 to 50% for adults; 25 to 33-1/3 for dead or minor plaintiffs		8
33-1/3% before trial; 40% through trial and appeal	2	9
33-1/3% before trial; 40% through trial and appeal (25 and 33-1/3% for dead or minor plaintiffs)		7
33-1/3% before trial; 50% with trial and appeal	1	5
33-1/3% before trial; 40% with trial; 50% through appeal		6
40% through trial; 50% appeal (25% for dead or minor plaintiffs)		3
40% through trial; 50% appeal	1	3
40% before trial; 45 to 50% if tried or appealed	1	4
25% before filing; 33-1/3% after filing; 40% after trial; 50% on appeal (Oregon State Bar Minimum Fee Schedule)		1
New Jersey Sliding Scale		8
Other		7

TABLE III-45.
HOURLY FEE OF DEFENSE ATTORNEYS (SELECTIVE SURVEY)

Hourly Fee	Number of Defense Lawyers
$35	1
$40	6
$45	4
$50	10
$60	2
Mean Fee	$47/hour
Median Fee	$50/hour

legal contingent fee system allows plaintiff lawyers to earn excessive fees", data were collected in both lawyer surveys on hours spent on cases by the lawyer responsible and his firm, and the fee earned by the lawyer. From these inputs effective hourly fee for the plaintiff lawyer was computed and compared with the normal hourly fee charged by defense lawyers in order to see if plaintiff lawyer fee seems unreasonably large. "Effective hourly fee" for any case is simply the fee earned divided by the plaintiff lawyer hours on the case. The average effective fee shown in Table III-46 for the two surveys was then calculated with all cases included, even if fee is zero because the plaintiff lost. Some explanation and caveats are needed concerning the derivation of these hourly rates. Only an approximate allowance could be made for co-counsel fee (i.e., the fee paid to the attorney who associated on the case). The survey data do not allow us to determine whether a case was associated with other counsel. Our surveys show that about four percent of the cases accepted were associated with other counsel. In addition lawyers referred cases amounting to about three percent of their accepted cases and may have served in a co-counsel capacity on these. It is reasonable to expect that lawyers engaged in the Selective Survey have substantially more cases brought *to* them than they themselves refer. The personal interviews support this impression. Thus a rough estimate of the percent of cases obtained by referral and involving associate counsel has been made at 10 percent for the National Survey and 75 percent for the Selective Survey. The latter figure was a conservative (i.e., low) estimate made by an attorney who conducted the personal interviews. The fee paid to the associating attorney varies from one-quarter to two-thirds of the total fee recoverable from an eventual award. As a result, a conservative estimate of one-third was used to obtain the mean effective fee excluding co-counsel share of fee. Therefore in the Selective Survey, the hourly fee of $84 is reduced by co-counsel share for the fraction of cases with co-counsel [i.e., reduced by $84 × (.33) (.75) = $21] for an adjusted rate of $84 – $21 = $63. Similarly in the National Survey the adjusted rate is $63 – [$63 (.33) (.10)] = $61.

TABLE III-46.
AVERAGE EFFECTIVE HOURLY FEE FOR PLAINTIFF LAWYERS

Survey	Mean Effective Hourly Fee Including Co-counsel Fee	Mean Effective Hourly Fee Excluding Co-counsel Fee
National Survey	$63	$61
Selective Survey	$84	$63

It should be clear to the reader that the calculated effective fee of about $61 to $63 is approximate for reasons discussed above. Furthermore, the lawyers' hours on the case and the reported fee were obtained from memory. Another word of caution must be offered concerning the percent of cases won by plaintiff. Although respondents were instructed to report their five most recent cases, there is reason to believe that they tended to recall their "winners" more than their "losers". This impression was offered by attorneys conducting the personal interviews. In fact a comparison of the plaintiff win rates reported by plaintiff attorneys is higher than that reported by defense attorneys in both surveys as shown in Table III-47 below.

Thus the true effective rate for the plaintiff lawyer could be somewhat lower than shown in Table III-46 because of

TABLE III-47.
PERCENT OF CASES WITH RECOVERY BY PLAINTIFF AS REPORTED BY DEFENSE VS. PLAINTIFF LAWYERS (SAMPLE SIZE SHOWN IN PARENTHESES)

Survey	Plaintiff Wins Reported By: Plaintiff Lawyer	Plaintiff Wins Reported By: Defendant Lawyer
National Survey	80% (59)	46% (26)
Selective Survey	84% (614)	62% (254)

the suspected upward bias due to over-reporting those cases won by plaintiff. This fact tends to strengthen the argument that effective hourly fee is not excessively high for plaintiff attorneys.

It should also be noted that this analysis does not include the legal costs which are sometimes advanced by the plaintiff attorney, but may not be paid by the claimant if he loses, even though he is responsible for these costs.

In spite of the limitations discussed above, the results presented in Table III-46 show that the plaintiff lawyers "effective hourly fee" is *not* excessively large at least in comparison to normal defense lawyer hourly fees, but rather plaintiff and defense fees are in the same general ballpark. No allowance is made for differences which might exist in plaintiff and defense lawyer overhead rate which would affect the net salary rates to the respective attorneys.

Uncompensated Hours

An analysis has been made of plaintiff lawyer hours spent on those cases which were lost by the plaintiff, in order to determine whether these are just trivial efforts or efforts which account for significant amounts of lawyer time per case lost. In addition, the economic worth of uncompensated efforts is estimated in order to identify what sort of costs claimants might be faced with, were it not for the contingent fee system. The distribution of plaintiff lawyer hours on cases lost by the plaintiff is given in Table III-48 for lawyers in the Selective Survey. The reader is reminded that the Selective Survey is not statistically projectable.

The National Survey had only six zero recovery plaintiff cases. Lawyer hours on these cases ranged from two to 200 hours, but the sample is too small for the distribution to be reliable.

The average or mean plaintiff lawyer hours spent on the 34 zero recovery cases in the Selective Survey is 440 hours per case. Clearly this is a substantial investment of time for a lawyer in private practice. Thus we conclude that uncompensated cases are by no means trivial efforts on the average.

From a claimant's perspective the contingent fee arrangement protects him from incurring an average legal fee of about $22,000 (i.e., 440 hours times $50 per hour) should he lose his case. Even using the lower median value of 240 hours the legal fee would be $12,000. In either case the legal fee would have to be added to the case expenses for which the plaintiff is always responsible. Case expenses reported by plaintiff attorneys averaged $400 in the National Survey and $2,200 among the Selected Survey of lawyers known to be engaged in medical malpractice litigation. Considering that the median family income in the United States was only $9,870 in 1970 (Current Population Reports, U.S. Bureau of Census Series P-60, No. 78, May 20, 1971), it is reasonable to expect that many claimants would not seek legal action, even though they thought they had a meritorious case, if the contingent fee system did not protect them from the risk of incurring such substantial legal fee and costs should they lose their case.

TABLE III-48.
PLAINTIFF LAWYERS HOURS ON CASES WITH ZERO RECOVERY (BASED ON SELECTIVE SURVEY DATA)

Lawyer Hours on Cases Lost by Plaintiff	Percent of Lost Cases with these hours
15 - 95 hours	24
100 - 110 hours	17
200 - 300 hours	24
400 - 1,000 hours	26
2,000 hours	9
Mean Hours = 440	
Median Hours = 240	

Expected Pay off Model

Model Development

In order to explain the influence of the contingent fee system on case acceptance behavior by plaintiff lawyers, an "expected payoff model" has been developed. The discussion of case acceptance criteria in Section III.B. shows that lawyers consider a wide range of factors in deciding whether or not to accept a case. In the expected payoff model we reduce these factors considered by the lawyer to their resultant economic considerations. This model is only an approximation to the complex real world with its jurisdictional and lawyer variations. Parameters used in the model are estimated using only data available from the Selective Survey because of the larger sample size this survey provides.

Equation (1) expresses the economic relationships involved in case acceptance. Although there is probably no lawyer who goes through the mechanics of writing down equation (1) explicitly, most lawyers can be expected to implicitly weigh the factors found in the equaiton. Equation (1) put into words says "expected legal fee" minus the "economic worth of the plaintiff lawyer's hours on the case" equals the "compensation differential" he receives. The Compensation Differential is the amount he earns over and above what a normal hourly rate would provide and might be due to many factors such as windfall, risk compensation, etc.

(A x F x P x R)	-	(D x H)	=	C	
Expected Fee		Worth of hours on case		Compensation Differential	(1)

where:

A = Amount of recovery (gross recovery) in dollars for cases won

F = Fee fraction (.38 on the average; .333 most common–see Section III.C.)

P = Probability of plaintiff winning (.79 on the average–see Section III.C.3.)

R = Fraction of fee retained after co-counsel fee (can be 1.0 if no associated counsel; or can range from .20 to .30)

D = Dollars per hour for lawyer's time ($50/hour will be used based on Section III.D.)

H = Hours on case by plaintiff lawyer

C = Compensation Differential (about $13/hour on case based on the average results–see Section III.D.2.a).

An Example

For a particular case a lawyer may estimate the expected amount of recovery, A, and the hours, H, that he thinks he will have to spend on the case. He can specify the hourly rate, D, he normally charges on hourly cases (e.g., $50/hour or some other rate). The lawyer may choose to estimate the probability, P, that his client will win based on a wide range of factors (e.g., evidence, expert witness, jury sympathy, etc.) or he may use the overall value of .79 found in Section III.C.3.d. Finally, he specifies R, the fraction of the fee he will retain. (E.g., R = 1.0 if no associated counsel, etc.). By substituting these parameters into equation (1) he can solve for C, his Compensation Differential. If C is negative this means that his expected earnings on this case are less than what he would earn at his hourly rate, D. By dividing C by H he can estimate his hourly Compensation Differential (or effective decrease in his hourly rate if C is negative).

Case Acceptance Region Based on Expected Payoff Model

A family of straight line curves can be plotted from equation (1). By keeping A and H as unknowns and using average values of the other parameters obtained from the Selective Survey, it is possible to illustrate the region of case acceptance which depends on estimated amount of recovery and lawyer hours needed for a case. This has been done in Figure III-5. The region above the horizontal axis is the theoretical acceptance region–i.e., combinations of recovery amount and case hours which at least pay the lawyer for his hours on the case at the average hourly rate ($50 based on average defense attorney rate).

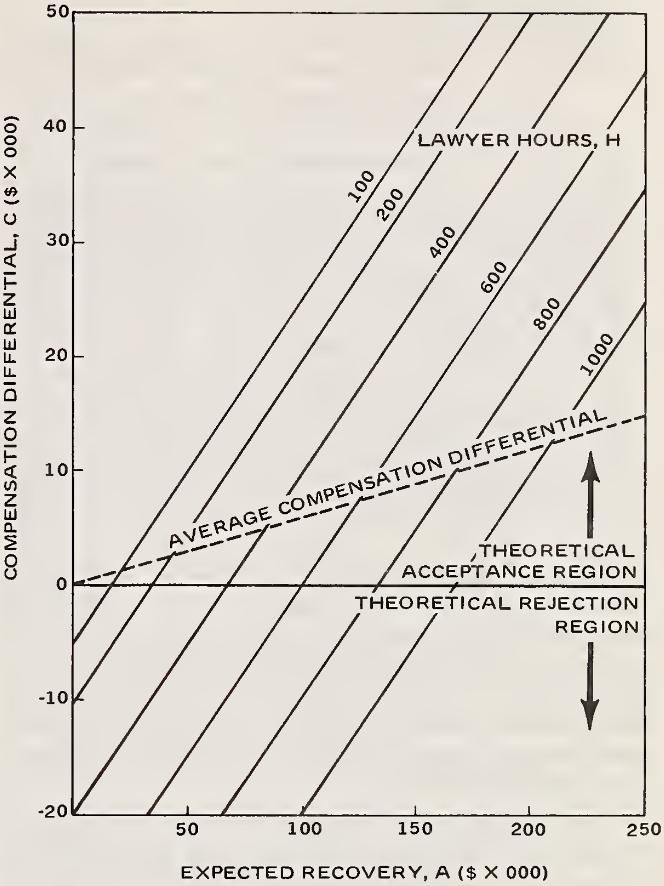


FIGURE III-5
CASE ACCEPTANCE REGION BASED ON MATHEMATICAL MODEL

Average parameter values used in Figure III-5 obtained from the Selective Survey results are:

Fee Fraction, F = .38
Probability of winning , P = .79
Fraction of fee retained, R = 1.0 (i.e., based on no co-counsel)
Hourly rate, D = $50/hour

Obviously other values could have been used for these parameters to produce a set of such graphs. The dashed line in Figure III-5 represents the average Compensation Differential, C, of $13/hour presented in Section III.D.

The reader should bear in mind that in reality amount of recovery, A, and the hours on the case, H, are directly related as shown in Figure III-4 of Section III.C. Also it must be recognized that a plaintiff attorney would be more willing to accept a case which might not yield an effective fee equal to his normal hourly fee if he has free time available and no immediate prospective cases.

Economic Rationale for Case Acceptance

Two common assertions concerning lawyer acceptance of medical malpractice cases are:

Assertion 1: "Meritorious cases are being rejected if the anticipated amount of recovery is small"

Assertion 2: "Nonmeritorious cases are being accepted if their potential recovery is large"

An analysis of the mathematical model with parameters provided by our survey data provides support for Assertion 1 but not for Assertion 2, assuming rational economic decision making on the part of the plaintiff attorney. It is difficult to define a "meritorious" case in an objective manner. Obviously the plaintiff might view a case as meritorious, while the defendant views the same case as nonmeritorious. Even supposedly objective observers may differ in their assessment of the extent of injury and issues of negligence and liability. It is reasonable that cases with clear medical injury, liability and proximate cause should result in a greater likelihood of the plaintiff recovering damages. Therefore, we will use probability of plaintiff recovering damages as an objective measure which should serve as a proxy for "meritoriousness". The reader should note that the above rationale is only valid if, in fact, cases which are "inherently meritorious" do, indeed have higher probability of recovery than cases which are not "inherently meritorious". The effect of the inherent merit of cases on lawyer acceptance under the contingent fee system is discussed on Page 120 ff.

A brief examination of equation (1) lends strong support to Assertion 1 since if P is increased from its average value of about .79 for all malpractice cases to the maximum possible value of 1.00, this only increases the "Expected Fee" term by about 25 percent. At the same time the expected amount of award, A, for a small recovery case may be below its mean value by much more than 25 percent and thus enter the theoretical case rejection region (i.e., the region where the lawyer would not earn his normal hourly rate on the average). Thus even if winning is certain it may not be worth the legal costs if the award is low. For example, if a case is expected to recover only $15,000 if won and if the plaintiff lawyer thinks the case will take at least 100 hours of his time, then he will earn less than $50/hour even if he is certain to win. This is not solely a consequence of the contingent fee system, however. If plaintiff lawyers had an hourly fee arrangement, a sensible claimant would think twice before incurring more legal expense than he can hope to recover. Thus, both with the contingent fee or fee for service, the small case is economically infeasible.

Assertion 2 is not supported by personal interviews with lawyers concerning their claims screening criteria (Section III.A). Furthermore, applying our practical definition, "nonmeritorious case = low probability of winning" to equation (1) shows clearly that as P approaches zero, so does "expected fee" even if A were very large. For example, suppose A were as large as $300,000 which is an unusually large recovery. The results of Section III.C. show that a lawyer would spend roughly 1300 hours on a case of this size. At $50/hour the legal fee should be $65,000. Since our example deals with a nonmeritorious case, let us assume that the probability of award is only a value of P = .10. Using the most common value of F = 33-1/3 contingent fee, this results in an expected fee of only $300,000 x (1/3) x (.10) = $10,000 which would compensate the plaintiff lawyer at a rate of less than $8/hour even if he had no co-counsel fees to pay.

Lawyer Comments on Contingent Fee Influence

In the personal interviews of the Selective Survey, lawyers were asked the following lead question:

> "How does the contingent fee arrangement influence the incidence and disposition of claims?"

The responses to this question can be classified into four types which are listed in Table III-49 below, along with the percent of respondents who gave answers of each type. Subsequent sections provide a further analysis of each type of response.

TABLE III-49.

TYPES OF RESPONSE CONCERNING CONTINGENT FEE INFLUENCE

Type Response	Percent of Lawyers With This Type of Claim
Effect on Number of Claims	26%
Influence on Meritoriousness of Claims	62%
Economic Influences	24%
Effect on Outcome of Litigation	93%

The sum of the percentages in Table III-49 exceeds 100 percent since respondents often provided several comments concerning contingent fee. All percentages in the three tables that follow are percentages of the 77 plaintiff lawyers or 27 defense lawyers responding to the lead question in quotes above. These percentages should not be expected to add to 100 percent. They should be interpreted as *relative* frequencies with which respondents cited various opinions.

Influence of Contingent Fee

A common criticism of the contingent fee arrangement is that its very existence as an economic relationship between a claimant and the legal system acts to increase the total number of claims.

From the total number of lawyers responding to the lead questions concerning contingent fee, opinions were equally divided on this issue. A somewhat surprising finding is that there was no significant difference in the relative percentage of opinions of the plaintiff and defense bars. That the contingent fee is more frequently addressed by the defense bar (almost twice the percentage of plaintiff respondents) indicates perhaps only that defense attorneys are more familiar with the contingent-fee/claims-incidence hypothesis. These results are shown in Table III-50.

TABLE III-50.

ATTITUDES REGARDING CLAIMS INCIDENCE

Attitude	Segment of Lawyers Responding*		
	Total	Plaintiff Bar	Defense Bar
The contingent fee has no effect on the incidence of claims	13%	10%	19%
The contingent fee increases the number of claims	13%	9%	22%

* Based on 104 lawyers responding, or 95 percent of those interviewed.

Influence of Contingent Fee on the Merit of Claims

Responses were analyzed for comment about the effect of the contingent fee on the inherent merit or justice of claims. One of the most serious criticisms of the contingent fee system is that it encourages "frivolous" claims or claims based on spite, malice, vengeance, or other ill-founded motives rather than on the conceptual standard of proper legal damages for a given legal injury. The argument most frequently advanced in defense of the contingent fee is that it is the best economic relationship between client and lawyer for the prosecution of meritorious litigation since the case outcome is uncertain.

Differences in the beliefs and attitudes of the plaintiff and defense bars became strikingly apparent in the tabulation of these results, which are shown in Table III-51.

TABLE III-51.

ATTITUDES REGARDING THE MERIT OF CLAIMS

Attitude	Segment of Lawyers Responding*		
	Total	Plaintiff Bar	Defense Bar
The contingent fee increases frivolous claims	6%	1%	19%
The contingent fee discourages frivolous claims	3%	4%	0
The contingent fee permits meritorious cases	53%	61%	30%

* Based on 104 lawyers responding, or 95 percent of those interviewed.

While only a tiny fraction of plaintiff lawyers expressed an opinion that the existence of the contingent fee acts to increase frivolous claims, almost one-fifth of the defense bar gave a response which could be so categorized.

An argument advanced in favor of the contingent fee is that it acts as a regulating mechanism in screening cases by plaintiff attorneys, yet only four percent of the plaintiff bar so responded. This is perhaps indicative of a contrived argument by plaintiff bar spokesmen or, equally likely, that the stated effect is simply so obvious to experienced practitioners that it was not frequently mentioned. Note that respondents were *not* asked the direct question, "Do you think the contingent fee arrangement acts as a regulating mechanism in screening cases?"

The second major difference based on party alignment is the view that the contingent fee permits meritorious cases. Over twice the percentage of plaintiff lawyers held this view than did their colleagues for the defense.

Economic Effect of Contingent Fee on the Claimant Attorney

Of peculiarly American widespread acceptance and custom, the contingent fee is said to allow redress to justice irrespective of the ability of the client to pay for the services of an attorney. It is frequently criticized as providing a windfall to plaintiffs' lawyers, especially for large awards on quick settlements. Categorizing the responses into areas which indicated a concern with the economic status of the client or the benefits to the lawyer led to the results displayed in Table III-52.

TABLE III-52.

ATTITUDES REGARDING THE ECONOMIC STATUS OF THE CLAIMANT OR ATTORNEY

Attitude	Segment of Lawyers Responding*		
	Total	Plaintiff Bar	Defense Bar
The contingent fee permits claims by poor people	18%	22%	7%
The contingent fee is unfair; the lawyer gets too much	4%	0	15%
Abolishment would permit spiteful claims by the wealthy	2%	3%	0

*Based on 104 lawyers responding, or 95 percent of those interviewed.

Noted in the table is that over three times the percentage of plaintiffs' lawyers expressed a concern for poor people in discussing the contingent fee than did members of the defense bar. Likewise, none of the plaintiff lawyers thought the contingent fee excessive in their behalf, although 15 percent of the defense bar respondents mentioned it. Of particular interest is that twice the percentage of defense lawyers dealt with the unfairness of their plaintiff brethren's fee than they did with the fact that the contingent fee unarguably permits claims to be made by the poor. This illustrates a greater focus of defense attorneys on the presumed negative aspects of the contingent fee arrangement than on the benefits afforded to the low income claimants. Furthermore Section III.D. shows there is little factual basis for the assertion that the contingent fee system provides excessive fees to plaintiff attorneys.

Only a tiny fraction, two percent, of the responses dealt with the issue of how those claimants wealthy enough to afford an attorney might abuse their economic status if the contingent fee were abolished. As would be expected, this infrequent but thoughtful observation was solely from the plaintiff bar.

Effect on the Disposition of Claims

A hypothesis frequently advanced in defense of the contingent fee is that since the plaintiff lawyer has an economic interest in maximizing the award, this self interest of the lawyer is in the interest of the claimant. This suggestion is countered by the assertion that the quality of legal services is not determined by economic factors alone, but by standards of professionalism transcending them.

Remarks recorded in the interviews which could be categorized as dealing with the question of the relationship between the contingent fee and the disposition of claims are summarized in Table III-53. It should be noted that responses on this topic were obtained from only 70 lawyer interviews, or 64 percent of the total.

TABLE III-53.

ATTITUDES REGARDING EFFECT OF CONTINGENT FEE ARRANGEMENT ON OUTCOME OF LITIGATION

Attitude	Segment of Lawyers Responding*		
	Total	Plaintiff Bar	Defense Bar
The contingent fee has no effect on the outcome of litigation	76%	83%	50%
The contingent fee gives better representation to the injured	10%	7%	19%
The contingent fee encourages settlement	4%	2%	13%
The contingent fee discourages settlement	3%	2%	6%

* Based on 70 lawyers responding, or 64 percent of those interviewed.

The overwhelming majority, more than three-fourths of the lawyers responding, stated affirmatively that the contingent fee does not influence the outcome of litigation.

LEGAL COMBINES

The following question was asked in both the mail surveys and the personal interviews of lawyers who had handled medical malpractice cases.

> "There have been some cases, for example the Thalidomide drug cases, where groups of plaintiffs' attorneys have combined forces to seek redress for a common grievance. Are you familiar with any such legal combines and how such groups form and function? Please describe: "

Familiarity

Most of the lawyers surveyed were not familiar with legal combines or groups of plaintiffs' attorneys combining forces to seek redress for common grievances. As Table III-54 shows, 71 percent of those lawyers in the National Sample and 64 percent of those in the Selective Survey were totally unfamiliar with legal combines and how they are formed and how they function. Another nine percent and six percent in the National and Selective surveys respectively indicated that they had only *heard* of legal combines and did not provide any sort of description. Thus, the lack of awareness of the presence and functioning of these combines seems to be the most striking feature of the responses. Furthermore, the question about legal combines was only asked of lawyers that have handled medical malpractice cases. It could well be expected that familiarity is even less among all private practice lawyers.

Of those who were familiar with legal combines, only a small percentage (2.9, 4.5 percent) indicated participation in them. All answers tended to be brief, with the typical response simply acknowledging familiarity and perhaps citing an example of a drug, drug company, or group. All examples are listed below in Table III-55 with the frequency of their occurrence.

Formation of Legal Combines

Most of the useful information on the form and function of legal combines came from the personal interviews. The answers given indicate that lawyers become aware of a common grievance held by different persons either in one area or sometimes several across the U.S. in several ways, including legal and medical association journals, association conventions, and personal friends who are also lawyers. Realizing the cost and great effort of case preparation, an individual lawyer might wish to seek assistance through the experience of others who are representing, or who have represented, persons with the same grievance. It was reported that the American Trial Lawyers Association (mentioned seven times) provides to its members a referral service of names of other lawyers who are interested in or already representing different clients with the same grievance. It could not be determined from the data whether or

TABLE III-54.

LAWYER FAMILIARITY WITH LEGAL COMBINES

Response	National Survey			Selective Survey		
	Number of Plaintiff Lawyers	Number of Defense Lawyers	Both*	Number of Plaintiff Lawyers	Number of Defense Lawyers	Both**
A) Familiar With Form and Function and:						
1) Indicated Participation	1		1	6	1	7
2) Indicated No Participation	2	1	3	9	4	13
3) No Indication	3		3	23	4	27
B) Heard of *Only*	1	2	3	8	1	9
C) Not Familiar	18		24	73	28	101

*Base of 25 responses from plaintiff lawyers and nine defense.
**Base of 119 responses from plaintiff lawyers and 38 defense.

TABLE III-55.

NUMBER OF LAWYERS MENTIONING VARIOUS TYPES OF LEGAL COMBINE CASES*

Type of Case	National Survey			Selective Survey		
	Number of Plaintiff Lawyers	Number of Defense Lawyers	Both	Number of Plaintiff Lawyers	Number of Defense Lawyers	Both
Birth Control Pill Group	1		1	6	2	8
Chlordycetin	1		1	1	2	3
Mar 29				2	1	3
Bo-Plant (Squibb)				1		1
Anti-Cholesterol Pill Group				1		1
Halothane				1		1
Aralen (Winthrop)					1	1
Polio Vaccine				1		1

*Answers refer to those respondents in Table 54, Part A.

not ATLA provides more than just this referral service, although it was described once as a "clearinghouse" and once as an "information bank". (See Table III-56)

Operation

From the data obtained, it was found that legal combines serve to provide a number of attorneys with information about a common problem. Names of expert witnesses, pleadings, transcripts of dispositions and trials, case results, and other materials which aid in case preparation are shared or made available. Some attorneys reported that although they had cases which technically were a part of a combine, they did not participate at all in the sharing of information with other attorneys. A favorable outcome of the first few cases is important to the eventual success of a combine, but unlike a class action suit in which a group of persons suffer a common injury and damages for which all may jointly sue, each claimant in a combine situation will have both a slightly different case to prove and possibly a different jurisdiction to prove it in. As a consequence some may lose while others win. For example, although the first case may establish that a certain pill is harmful, it will still be necessary to show that a certain minimum dosage was in fact prescribed and taken by the claimant. Accordingly, although a combine may better prepare an attorney, the outcome of each case will depend on the facts and attorney's skill.

INFLUENCE OF RULES, STATUTES, AND LEGAL DOCTRINES

Background Statement

Certain key legal doctrines have historically had the effect of discouraging, or in fact barring, the bringing of an action for medical malpractice in many circumstances. One such doctrine is the doctrine of charitable immunity, which until recently had often prevented the bringing of an action against a charitable hospital. A more significant issue, perhaps, is the requirement of expert testimony to establish negligence. A number of key legal doctrines have been abolished, modified, or ameliorated by new doctrines which have made establishing the plaintiffs case somewhat easier. Examples include *res ipsa loquitur*, fraudulent concealment, abolition of charitable immunity, and relaxation of the locality rule.

This section contains a definition and discussion of these doctrines and how they operate either to hinder or to facilitate malpractice actions. Statistical data will be presented and interpreted to indicate the effect these doctrines have had on the outcome of appellate decisions and on the initiation of cases. These analyses will be examined for a number of individual key states and for the trends which have developed, particularly in the past 20 years. Such other parameters as the type of defendant, the illness, and the treatment will also be analyzed as to their effect on the outcome of appellate cases.

Section II.B presented the methodology utilized in conducting the legal doctrines study. It is important to emphasize that the following results are based on an analysis of reported appellate decisions which does not reflect malpractice litigation at the trial level. It would not have been possible within the time and resources available to compile a comparable data base of trial records and determine the impact of various legal doctrines on the outcome of trial cases. On the other hand, appellate decisions are readily available in published form and legal doctrines are a prime subject of discussion in these opinions.

The frequency of reliance on a particular legal doctrine in appellate decisions is not always a reliable indicator of its importance. For example, the abolition of the doctrine of

TABLE III-56.

NUMBER OF LAWYERS REPORTING VARIOUS FORMS AND FUNCTIONS OF LEGAL COMBINES*

	National Survey			Selective Survey		
	Number of Plaintiff Lawyers	Number of Defense Lawyers	Both	Number of Plaintiff Lawyers	Number of Defense Lawyers	Both
Form						
A) Ass'n of Trial Lawyers of America				5	2	7
B) California Trial Lawyers Association				1		1
C Defense Research Institute					1	1
D) Association of Private Attorneys for Information Exchange	1		1	5	1	6
Function						
A) Aids Discovery Process	4		4	10	2	12
B) Saves Legal Research	1		1	9	2	11
C) Other				2	1	3

* Answers refer to those respondents in Table III-54, Part A.

charitable immunity may influence the initiation (and certainly the outcome) of suits against hospitals. After a rule or doctrine has been firmly established, however, it is less likely to be an issue in an appellate case. The liberalization of the discovery process has been a significant boon to plaintiffs' lawyers in helping them obtain access to medical records and other evidence. However, the rules of discovery frequently do not show up as an issue on appeal. Conversely, various doctrines relating to expert testimony are likely to be raised on appeal because of the need to decide whether the particular set of facts justified the application of the doctrine. Two examples include the locality rule, which requires a local expert familiar with the standard of care normally exercised in the particular geographic community, and *res ipsa loquitur*, wherein a particular set of facts may allow an inference of negligence, which requires the defendant to present some refuting evidence.

Definition and Influence of Key Rules, Doctrines, and Issues

This section of the report presents a discussion of key rules of law, doctrines, and issues. It is greatly oversimplified and generalized to aid the reader not learned in the law in comprehending the scope and impact of the analysis which follows.

Standard of Care

Standard of care has been defined as those acts performed or omitted that an ordinary, prudent person in the defendant's position would have done or not done. It is a measure to which the defendant's conduct is compared to ascertain whether or not there was a breach of legal duty which would constitute negligence.

Most malpractice actions are founded on the legal theory of negligence and have as their central issue the failure of a physician to exercise the requisite skill and care. In malpractice actions, reasonableness of a physicians's conduct is determined by the performance of other physicians under like conditions. The physicians's performance is compared with: (1) the degree of ability or skill possessed by other physicians in the same or similar community, neighborhood, or locality; (2) the degree of care, attention, diligence, or vigilance ordinarily exercised by those physicians in the application of their skill; and (3) the special or extraordinary skill of the specialist, if the physician involved has represented himself as being a specialist.

Proximate Cause

Proximate cause is a legal concept which requires proof of a factual connection between the malpractice (or breach of duty) and the patient's injury. In medical malpractice cases, as opposed to other types of negligence suits, a problem often arises in determining whether the malpractice was the proximate cause of the ultimate harm of injury to the plaintiff or whether the underlying disease or injury itself caused the harm. Absent the establishment of a causal connection between the acts of the defendant physician and the harm or injury suffered, a plaintiff may not state a cause of action in negligence.

Burden of Proof

In malpractice cases, as in other negligence cases, the burden of proof is on the plaintiff. This means that the plaintiff must persuade the jury by a "fair preponderance of the evidence" that the defendant was negligent. If plaintiff does not fulfill his burden of proof, his case may be dismissed or a verdict for the defendant may be entered by the court. The burden of proof in a civil action is not as stringent as that required in a criminal action. Thus, the plaintiff in a malpractice suit need not show that the defendant was negligent "beyond a reasonable doubt."

Expert Testimony

In order to give the trier of fact the best possible evidence on which to base its verdict, opinion evidence is not permitted to be introduced at trial, as a general rule. However, under certain circumstances, opinion evidence will be admitted. Two elements normally are required to warrant the use of expert testimony. First, the subject matter of the testimony must be so distinctively related to some science, profession, business, or occupation as to be beyond the ken of the average layman. Second, the witness must have such skill, knowledge, or experience in that field or calling as to make it appear that his opinion or inference will probably aid the trier of fact in the search for truth. In some fields this knowledge may be derived either from reading or from practice. More commonly, both reading and practice are required.

Qualifications of Expert

Generally speaking, a party need only make a showing of minimal qualifications in order to enable a witness to give expert or opinion testimony. The test is whether the opinion offered will be likely to aid the trier in the search for truth. In light of that purpose, courts follow the practice of excluding all but the very best quality testimony. Thus, a general practitioner may testify concerning matters within a medical specialty only if his education or experience, or both, involve demonstrable knowledge of the subject.

All circumstances and jurisdictions do not require skilled witnesses on a medical subject to be duly licensed to practice medicine. The general rule is that anyone who is shown to have special knowledge and skill in diagnosing and treating human ailments is acceptable to testify as an expert if his learning and training show that he is qualified to give an opinion on the particular question at issue. It is not even essential that the witness be a medical practitioner. A non-medical witness who has had experience in electrical work, for example, may testify to the effects of electrical shock upon the human body. Optometrists, whose training includes instruction in the symptoms of certain eye diseases, may testify to the presence of cataracts discovered in the course of fitting glasses and to the effect of a scar upon vision. The kinds of witnesses whose opinions courts have received even though they lacked medical training and would not be permitted by law to treat the conditions they describe are legion. The principle to be distilled from the cases is plain. If experience or training enables a proffered expert witness to form an opinion which would aid the jury, his testimony will be received in the absence of some countervailing consideration.

Locality Rule

In order to determine whether a physician may be liable for injury sustained by a patient, it is necessary to determine whether the injury was caused by the physician's breach of the standard of care owed to his patient. The determination of standard of care depends upon the rule applicable within the jurisdiction in which the cause of action arises. The most restrictive rule is that the measure of a physician's duty of care to a patient is that degree of care, skill, and diligence used by physicians, generally, in the same locality or community. A more expansive rule is that a physician owes that degree of care to a patient which is exercised by physicians, generally, in the same or similar localities or communities. The rationale for the more expansive rule, which is being applied more widely by courts today, is that the emphasis on locality no longer exists in the light of better communications as well as the standardization of hospital procedures and physician licensure brought about by state statutes and regulations. Where expert testimony has been received to show the standard of care in similar communities, the jury instructions should be extended to include the phrase "or similar communities." Some courts have stated support for a standard of care even broader than the "community" rule. These courts stress that locality is only one factor to be considered in determining the degree of care required of medical practitioners.

Defendant as Adverse Expert Witness

Under certain circumstances the plaintiff may wish to call to the stand the defendant physician, himself, question him as an adverse witness, and qualify him as an expert. Thus, the plaintiff may establish the standard of care required of physicians out of the mouth of the defendant. There are several advantages to calling the defendant to the stand. He may be questioned by the plaintiff's lawyer as an adverse witness and, as such, unlike other witnesses called by the plaintiff, subjected to leading questions and impeachment (challenge through other facts or testimony) of his testimony. Since the defendant himself will establish the standard of care against which his conduct will be measured, his testimony may not be attacked even under the most strict and narrow application of the locality rule.

Res Ipsa Loquitur

Literally translated *res ipsa loquitur* means "the thing speaks for itself." Ordinarily a plaintiff in a negligence case must specifically prove the acts or omissions constituting the defendant's negligence or be nonsuited. However, in some situations, the plaintiff may be entitled to have his case reach the jury even though he produces no direct proof of acts or omissions contituting negligence on the part of the defendant. In such cases, it is the doctrine of *res ipsa loquitur* which allows the plaintiff to reach the jury even though he has produced no direct proof of negligence.

The doctrine of *res ipsa loquitur* does not become operative unless the plaintiff proves the following: (1) that the event is such as will not ordinarily occur in the absence of negligence; (2) that the agency or instrumentality causing the harm was in the exclusive control of the defendant; and (3) that the event was not due to any contribution on the part of the plaintiff. It is sometimes said that there is a fourth requirement, namely that the evidence be more readily accessible to the defendant than it is to the plaintiff. This requirement, however, cannot be regarded as indispensable.

Res ipsa loquitur is merely the name given to a legal doctrine which creates an inference of negligence. In the majority of jurisdictions, the doctrine has the effect of creating a permissible inference of negligence. Under such circumstances, once the plaintiff proves the necessary conditions to call the doctrine into operation, he is entitled to a jury instruction to the effect that if the jurors believe the plaintiff's evidence, they may infer that the defendant was negligent and that the negligence of the defendant was the proximate cause of plaintiff's injury. However, the plaintiff is not entitled to a directed verdict by the judge in his favor even if the defendant does not offer rebuttal testimony, because an inference still requires that the jury render the verdict.

Perhaps the majority of jurisdictions also hold that the doctrine of *res ipsa loquitur* may not apply where expert testimony is necessary to prove that the injury ordinarily would not have occurred but for the defendant's negligence. The rationale for this principle is that no presumption or inference of negligence arises merely because the medical care or surgical operation terminated in an unfortunate result that would have occurred even though proper care and skill had been exercised and where the common knowledge or experience of laymen is not sufficient to warrant their passing of judgment. In such cases the doctrine of *res ipsa loquitur* may not be invoked, and expert testimony in support of the plaintiff's claim is an indispensable requisite to sustaining a right of action.

In the evolution of the law, the doctrine of *res ipsa loquitur* has been applied with frequency to medical malpractice cases only recently. Courts are becoming less and less reluctant to apply the doctrine due to the judicially perceived "conspiracy of silence" which some allege exists on the part of the medical community insofar as expert testimony is involved.

Charitable and Governmental Immunity

The doctrines of charitable and governmental immunity, when applied, act as a complete bar to a cause of action. Should a court find these doctrines to be applicable under a given set of circumstances, the plaintiff will not be permitted to bring or maintain his lawsuit.

Charitable Immunity

The doctrine of charitable immunity is applicable in a dwindling number of states to hospitals organized in such a manner that no profit from their operation will inure to the benefit of any individual. If any profit is realized from their operation, it is utilized for the improvement of the hospital's facilities and services. While the definition of a charitable hospital or institution may vary slightly from state to state, the concept that is basic to all definitions is that no profit can inure to the benefit of individuals. A hospital that would most frequently be included within the definition of charitable hospitals is referred to by some writers and the American Hospital Association as a voluntary nonprofit hospital.

The rationale which underlies the doctrine of charitable immunity is as follows: (1) preservation of the assets of the charity; (2) waiver of the patient's right to sue for negligence by accepting the charity; (3) the basic unfairness, either assumed or stated, in terms of applying a doctrine such as *respondeat superior,* which is geared to commercial pursuits, to a nonprofit enterprise; and (4) increased financial demands upon the assets of the charity as a result of adverse judgments. There have always been several exceptions to the application of the rule of charitable immunity; a charity may be held liable for the negligence of an agent of the institution; a charity may be held liable to a "stranger," i.e., one who is not a "beneficiary"; and, sometimes, a charity may be held liable only to the extent of its nontrust assets. The general trend today is toward the complete abolition of the doctrine of charitable immunity.

The marked trend toward abolition of the doctrine is understandable. The illogical and conflicting bases upon which the doctrine was founded, the unfairness of forcing the injured party to contribute indirectly to the charity by refusing him the opportunity to recover, and the availability of liability insurance have all contributed to the willingness of the courts to overturn or modify the doctrine.

Governmental Immunity

While, as a general proposition, a negligent act gives rise to tort liability for that act, the government, subject to certain qualifications, cannot be sued for the negligent acts of its officers, agents, or employees unless it consents to such a suit. This concept of governmental immunity has its origin in the ancient common law doctrine that the King could do no wrong, and so could not be sued in his own courts for the torts of his agents. With the transfer of sovereign power from the crown to the state, new reasons had to be formulated to support sovereign immunity. The most succinct statement of this reasoning is by Mr. Justice Holmes who wrote: "A sovereign is exempt from suit, not because of any formal conception of obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends." Whatever reasoning is used, the principle is firmly established that a state cannot be sued without its consent.

It is equally well established that political subdivisions of the state are immune from liability when engaged in a governmental function. This rule rests on the reasoning that since political subdivisions are arms of the state, necessary to enable the state to carry on its governmental functions, they should enjoy the protection of sovereign immunity when engaged in governmental functions. As with charitable immunity, the trend regarding the doctrine of governmental immunity is towards an increasing willingness on the part of the courts to impose liability as the states and the federal government enact statutes to waive their immunity in tort suits.

Respondeat Superior

Respondeat superior is a form of vicarious liability whereby an employer is held liable for the wrongful acts of an employee even though the employer's conduct is without fault. Before liability predicated on *respondeat superior* may be imposed upon an employer, it is necessary that a master/servant relationship exist between the employer and employee and that the wrongful act of the employee occur within the scope of his employment. The test for determining whether a master/servant relationship that is sufficient to invoke the doctrine of *respondeat superior* exists is whether the employer has the right to control the physical conduct of the employee in the performance of his duties. An act is within the scope of employment if it is so closely related to what the employee has been hired to do, or so fairly and reasonably incidental to his employment, that it may be regarded as a method, although improper, of carrying out the orders of the employer.

The doctrine of *respondeat superior* does not absolve the original wrongdoer, the employee, of liability for his wrongful act. Not only may the injured party sue the employee directly, but the employer may seek indemnification from him.

The doctrine of *respondeat superior* does not apply to instances of wrongful conduct on the part of an independent contractor. An independent contractor is usually an agent of a principal over whom the principal has no right of control as to the manner in which the work is to be performed. The lack of the right of control makes the enterprise that of the independent contractor, rather than that of the employer.

However, as may be observed in *Darling vs. Charleston Community Memorial Hospital,* 33 Ill.2d 326, 211 N.E. 2d 253 (1965), a hospital can be held liable for an independent contractor's negligent acts, not on the basis of *respondeat superior,* but rather on the theory that a hospital has a duty " . . . with respect to actual medical care of a professional nature such as is furnished by a physician . . . to use reasonable care in selecting medical doctors." In *Darling,* the hospital's own by-laws established the duty, and a breach of this duty imposed liability regardless of the legal relationship otherwise accorded a physician working in an institutional setting.

In addition to the foregoing general principles, the "borrowed servant" doctrine may apply in certain fact situations to impose liability under *respondeat superior* upon a physician or surgeon rather than upon a hospital for acts or omissions of hospital personnel. The "borrowed servant" doctrine is sometimes applied in the context of the operating room where, it is said, the surgeon is the "captain of the ship," in absolute control of the operating room and of the persons assisting him (and borrowed from the hospital).

The manner in which the *respondeat superior* and "borrowed servant" doctrines are applied is illustrative of the manner in which the courts have sought to allocate liability upon some fair principle, and to encourage that division of responsibility which is most beneficial to patient, physician, and hospital alike.

The Tort of Battery and the Doctrine of Informed Consent

The intentional touching of another's person without his authorization is a legal wrong, a battery. It then follows that any intentional touching must be authorized either expressly or impliedly or else liability for a battery may be imposed.

Procedures ranging from surgery to radiology involve the touching of a patient's person. Even procedures involving a simple movement of a limb constitute such a touching. Therefore, medical and surgical procedures must be authorized by the patient, or the person performing the procedure can be subject to an action for battery.

The question of liability for performing a medical or surgical procedure without the patient's consent is separate and distinct from any question of negligence in performing the procedure. Liability will be imposed and damages will be awarded because there was a non-consensual touching of the patient. In legal theory, it is of no consequence that a medical procedure constituting a battery improved the patient's health.

The consent of the patient to treatment and substantial proof of that consent are needed by a physician before treatment is begun in order to prevent liability from accruing because of an allegedly unlawful touching of the patient An authorization from the patient, however, without a full understanding of what he is consenting to, is not an effective, or "informed consent." The patient must receive sufficient information to make his consent effective. This "informed consent" issue involves the patient's assertion that he was not given sufficient information by his physician to exercise his freedom of choice. In such an instance the patient is asserting that he was denied his right to make an intelligent choice from among the various courses of treatment possible or to refuse or reject a specific course of treatment.

Generally speaking, there are two tests which have been used by courts in recent years to determine whether the physician furnished enough information to the patient so that his consent is "informed." The first is the objective test. It is objective in that the physician is required to give as much information concerning a contemplated procedure as is ordinarily given about the same procedure by other physicians in the community. The test here is whether the physician followed the general practice of disclosure customarily followed by the medical profession in the community or locality. The second test has been called a subjective one. Under it the physician can be held liable if the jury finds that the patient did not receive enough information to allow him to give an informed consent. Thus, if the patient had not been warned about a possible consequence of the procedure which subsequently materialized, the jury is likely to find that the failure to give this information may have induced authorization from the patient which otherwise would have been denied. The subjective test, however, is not purely subjective since it also employs an objective standard within it. That is, the patient must normally show that a reasonable patient in his circumstances would have withheld consent had he been informed of the risk or consequence which materialized. Under the subjective standard, the patient need not introduce expert testimony as to the standard of disclosure in the community.

The most recent judicial decisions in the area of informed consent have imposed an affirmative duty of disclosure upon physicians. The duty is operative whether or not the patient inquires as to specific risks.

Statute of Limitations

Statute of limitations may be defined as a legal limit on the time one has to file suit in a civil matter. In 19 states, special statutes of limitations have been enacted which apply only to malpractice actions. Of these, several specify a limitation on actions brought either for negligence or on a theory of control (see III.F. below), but the majority seem to apply the special limitation to negligence actions, only.

With the exception of those states providing a special (ordinarily shorter) limitations period, general statutes govern.

Where the basis for an action in contract exists, the generally longer contracts statute of limitations usually applies, making an attempt at basing an action in contract attractive if the period for bringing an action in tort has been allowed to run. Of course, because the measure of damages in contract is invariably considerably below that in tort, an action in contract is not usually the theory of choice.

Date of Injury or Negligence

For the purposes of medical malpractice actions, the general rule is that the period of limitation commences when the cause of action accrues and that the cause of action accrues at the time the wrongful act is committed.

The Discovery Rule

To mitigate the harshness of the general rule as to statute of limitations, some jurisdictions have adopted the "discovery rule," under which the statute of limitations does not commence to run until the wrongful act is discovered or, with reasonable diligence, should have been discovered.

In some jurisdictions, by statute or through judicial decision, application of the "discovery rule" is limited to cases involving a foreign object left in the body of a patient. The reasoning behind this limitation is the prevention of fraudulent claims by plaintiffs. For a plaintiff in a malpractice case to avail himself of the "discovery rule" under such circumstances he must establish that a foreign object was, indeed, left in his body. The current trend seems to hold that the foreign object exception applies to surgical tools where the very presence denotes negligent action but cannot be logically extended to include the introduction of anesthetics or other drugs into the body., However, the foreign object "discovery rule" has been applied to objects that remained in the patient's body intentionally, such as a prosthesis inserted in a broken hip.

Some states have adopted statutory rules in malpractice cases which impose double time limits within which an action for malpractice may be brought. Typically these statutes provide that the action must be brought within a certain specified time after its discovery as well as within a specific time from the date the negligent act occurred.

Fraudulent Concealment

Normally "fraudulent concealment" will extend the beginning of the statute of limitations until the concealment ceases. While it now generally is recognized that there is a fiduciary relationship between a physician and his patient which imposes a duty of disclosure upon the physician, the courts in malpractice cases initially adhered to a requirement of affirmative misrepresentation. The rule with regard to fraudulent concealment may be embodied either in the case law or in express statutory enactments. It applies to constructive as well as to actual fraudulent concealment. For example, failure to allow the inspection of hospital records by a party who has a valid interest in them may subject the hospital to a charge of fraudulent concealment and thereby extend the statute of limitations. Fraudulent concealment will extend a statute of limitations even though the statute makes no reference to such an exception. In such situations, however, determining whether fraudulent concealment prevent a plaintiff from seeking timely remedies is an issue for the jury.

Warranty and Breach of Contract

Normally, actions against physicians will be based on negligence, but in certain circumstances the plaintiff will bring his action in warranty or breach of contract. As previously mentioned, one of the advantages to bringing an action in warranty or breach of contract, rather than for negligence, is that the statute of limitations is usually longer.

A warranty action may be brought and maintained if there is an express warranty offered by the physician to the patient. This warranty may arise if the physician promises or seems to promise that the medical procedure to be used is safe or will be effective.

If there is an express agreement which the physician breaches, the patient then has a remedy in contract. There are generally two types of express contracts between a physician and his patient: those based upon the physician's promise to perform a certain kind of service for a specified amount of money and those based upon the physician's promise to achieve a specified result or cure, or to utilize a certain procedure.

Procedural Issues

Many malpractice cases are appealed for purely procedural reasons that have nothing to do with either the nature of the case itself or its substantive merits. A case may never come to trial because the plaintiff's initial statement of his claim in court was defective. A trial judge may refuse to allow certain testimony to enter into evidence, lack of which will cause the plaintiff to lose his case. In certain circumstances trial judges may make prejudicial remarks about either party which will result in an unfair trial, or one of the parties in the case may make remarks so prejudicial as to warrant an immediate dismissal of the suit. If a case is dismissed because of prejudicial remarks, the dismissal often is ordered "without prejudice" so that the suit may be reinstituted. At other times, a new trial may be ordered.

Instructions to Jury

At the close of both plaintiff's and defendant's evidence, both parties may submit proposed jury instructions for the judge's consideration. The trial judge decides what instructions to the jury are proper in light of the circumstances of each case. After this discretionary decision is made, the trial judge instructs the jury on the law applicable to the case and directs it to apply that law to the facts as it finds them. If the trial judge states the law improperly or inaccurately, or permits unduly prejudicial instructions to be given to the jury, an appeal based on that alleged error may be maintained by the aggrieved party.

Pleadings

Pleadings may be defined as the formal allegations by the parties of their respective claims and defenses for the judgment of the court. Pleadings normally begin with the plaintiff's complaint and are followed by the defendant's answer. Although pleadings today are becoming less and less formal and few jurisdictions now follow the rigid formal "common law" system of pleading, it is nonetheless important that the pleadings be framed in such a way as to preserve the technical propriety of the suit and to produce a proper issue. Failure to frame the pleadings in such a manner may result in the dismissal of the plaintiff's case before trial upon defendant's motion that the pleadings fail to state a cause of action. Here, however, a claimant may be granted leave of court to restate his claim so as to present litigable issues, if this can be done.

Discovery Process

The discovery process is a pre-trial procedure that has as its purpose the ascertainment of facts to aid in the definition and clarification of the real issues in dispute between the parties by making evidence held by one party available to the other. The discovery process is regulated on the federal level by Federal Rules of Civil Procedure 26 through 37, which have been widely adopted in whole or in part by many states and their courts as well as by federal courts. There are five basic types of discovery techniques utilized today: depositions, interrogatories, motions for inspection and copying, motions for physical and mental examinations of parties, and demands for admissions. The discovery process, as exemplified by the federal rules, has been one step towards streamlining congested court calendars. In cases in which it can be shown either that one party rather than the other is entitled to a judgment in his behalf or that there is no real issue of fact involved and that the judge may properly enter a judgment for one of the parties without conducting a full trial, utilization of discovery procedures may result in a judgment on the pleadings as a summary judgment before the trial.

Most Important Rules and Doctrines

This section addresses the question of which rules or doctrines are most frequently applied in appellate decisions and which are the most significant to either the acceptance, processing, or outcome of a malpractice case.

Frequency of Application

Table III-57 compares the frequency of application of the key legal issues and doctrines in malpractice appellate decisions over time. The table is presented in ranked order with the most frequently applied doctrine appearing first. Since several doctrines are usually applied to each case, the percentages total to well over 100 percent. As noted at the bottom of the table, an average of 2.08 doctrines was applied to each case in the 1961-1971 timeframe, as compared with 2.04 doctrines per case in the 1950-1960 timeframe. All of the top five issues relate to matters of proof—usually the need to prove negligence. As might be expected, the need for, and acceptability of, expert testimony is a foremost issue.

Res ipsa loquitur has been an issue in an increasing percentage of appellate decisions in the past 20 years. It was considered in 13.4% of the cases in 1961-1971 as compared with 6.3% of the cases prior to 1950.

Procedural issues, the statute of limitations, instructions to the jury, and *respondeat superior* were all raised as issues in at least 10% of the appeals in the last decade.

Informed consent, warranty, and contract have also become relatively more significant legal doctrines since 1961. Table III-57 indicates that consent was only an issue in 2% of the cases prior to 1950, whereas it was an issue in 6.6% of the cases in the 1961-1971 period. Likewise, warranty and contract were issues in only 1.7% of the cases prior to 1950 and in 4.6% of the cases in 1961-1971.

Frequency of Significance to Outcome

In contrast to Table III-57, which arrayed those doctrines that were an issue in the appellate case, Table III-58 presents only those doctrines that were found to be "most significant" to the outcome of the appeal. Generally, only one doctrine was chosen as "most significant" to the outcome of the case. However, in a few instances where two doctrines had to apply simultaneously to obtain a result, both were coded as "most significant." Consequently, there was an average of 1.13 doctrines applied to a case in the 1961-1971 timeframe.

The compiled list of legal issues (Table III-57) is not substantially different from the list of those "most significant" (Table III-58) except that such general issues as burden of proof and standard of care are "most significant" in a smaller percentage of cases. In comparing the tables, it is noted that, whereas burden of proof was an issue in 38.3% of the cases prior to 1950, it was the "most significant" issue in only 31.1% of the cases, or 81% of those cases in which it was an issue (31.1/38.3). In 1961-1971, burden of proof was an issue in 29.2% and "most significant" in 19.0% of the cases, or 65% of those cases in which it was an issue. Conversely, prior to 1950, *res ipsa loquitur* was an issue in 6.3% of the cases and "most significant" in 2.1% of the cases or only 33% of those cases in which it was an issue. And in 1961-1971, *res ipsa* was an issue in 13.4% of the cases and "most significant" in 8.0% of the cases or 60% of those cases in which it was an issue. Hence there is an observed trend toward application of more specific doctrines, particularly relating to matters of proof.

Also noted in the tables is the fact that the statute of limitations has become a more significant issue in recent years. This is perhaps due to appellate courts grappling with the harshness of the general rule in cases where the discovery of the injury could not have reasonably occurred before the statutory period had elapsed.

The informed consent and warranty doctrines are similar in both tables.

The infrequent occurrence of charitable immunity as a significant doctrine is explained by the fact that the doctrine was rejected in many states 15 to 20 years ago, before the significant rise in the number of appellate decisions. This is true in such large and relatively active malpractice states as New York and California. Another reason for its relatively infrequent application is that once a doctrine as clear as charitable immunity has been definitely overturned, it is less likely to be an issue in a future appellate decision. In other words, a doctrine which is a prime issue in a number of cases before it is overturned is likely to disappear almost entirely as an issue after it is overturned.

It may be noted that *respondeat superior* was applied to 10.5% of the cases in the entire timeframe from 1950 to 1971 and that this doctrine was the most significant issue on appeal in only 4.1% or 6.4% of the cases in 1961 to 1971 and 1950 to 1960, respectively. It is most likely that some other doctrine relating to matters of proof will be the

TABLE III-57.

FREQUENCY OF ISSUES APPLIED TO MALPRACTICE APPEALS RANK ORDER

Rank (1961-71)	Issues or Doctrines Applied	Percentage of Cases		
		1961-71	1950-60	Pre-1950
1.	Burden of Proof	29.2	35.5	38.3
2.	Expert Witness—need for, locality rule, and adverse witness	29.2	24.5	37.3
3.	Standard of Care	26.9	26.5	26.7
4.	Proximate Cause	15.5	13.0	10.3
5.	*Res Ipsa Loquitur*	13.4	14.0	6.3
6.	Procedural Issues	13.7	13.5	13.3
7.	Statute of Limitations	13.2	10.5	11.0
8.	Instructions to Jury	11.8	9.0	19.0
9.	*Respondeat Superior*	10.5	10.5	14.0
10.	Informed Consent	6.6	3.5	2.0
11.	Charitable Immunity	4.6	5.0	6.0
12.	Warranty/Contract Breach	4.6	2.0	1.7
13.	All Other	28.4	36.0	30.6
Average Number of Doctrines Applied per case		2.08	2.04	2.16

major issue in many cases involving *respondeat superior.* Further, this issue generally applies only where a hospital or other institution is a defendant. Thus, the possibility of applying the *respondeat superior* doctrine existed only in the 28% of the cases studied that involved institutional defendants. If the percentage of cases in which *respondeat superior* was the most significant legal issue is applied only to those cases, the doctrine can be observed to be a quite significant one. In light of the rejection of charitable immunity, one would expect *respondeat superior* to have become a more common issue in recent years, as voluntary hospitals are being sued for malpractice.

Groupings of Doctrines

Many of the key issues or doctrines discussed above are, in the final analysis, hard to distinguish from each other and hence it is difficult to view their significance independently. Table III-59 summarizes the listing of "most significant" doctrines contained in Table III-58 into groups subtotals. These subtotals represent the percentage of cases in which any one or more of the doctrines in the subgroup was found to be significant to the outcome of the case. It is interesting that, in 1961-1971, general matters of proof were significant to the outcome in 40.9% of the cases and expert-related matters of proof (a major factor in proving any alleged malpractice) were significant in 20.0% of the appellate cases.

Importance of Doctrines to Acceptance and Processing of Cases by Lawyers

The mail survey of two populations of lawyers and the personal interviews in the Selective Survey included the following question:

> "Please identify any statutes, rules of substantive law, procedure, evidence, or other factors which you believe have the greatest bearing on your

TABLE III-58.

FREQUENCY OF ISSUES SIGNIFICANT TO OUTCOME OF MALPRACTICE APPEALS (RANKED ORDER)

Rank (1961-71)	Issues or Doctrines Most Significant to Case Outcomes	Percentage of Cases		
		1961-71	1950-60	Pre-1950
1.	Burden of Proof	19.0	26.1	31.1
2.	Standard of Care	16.8	13.3	14.8
3.	Expert Testimony—need for, locality rule, adverse witness	13.4	8.5	16.6
4.	Statute of Limitations	11.9	6.9	7.4
5.	Proximate Cause	8.5	5.9	6.4
6.	*Res Ipsa Loquitur*	8.0	8.0	2.1
7.	Procedural Issues	5.1	5.3	3.9
8.	Informed Consent/Consent	4.6	2.7	1.1
9.	*Respondeat Superior*	4.1	6.4	7.1
10.	Instructions to Jury	4.1	4.8	8.8
11.	Charitable Immunity	3.2	3.7	3.9
12.	Warranty/Contract Breach	2.7	1.6	.7
13.	All Other	11.6	19.2	13.2
	Average Number of Doctrines Significant to outcome of case	1.13	1.12	1.17

A. acceptance of cases
B. processing of cases."

Tables III-60 and III-61 summarize the responses from these surveys to this two-part question. Percentages are based on the number of those responding to this particular question, rather than on all respondents to the survey.

It is interesting to note that the requirement for expert testimony is also considered the most significant issue from the perspective of lawyers, both with respect to their acceptance of a case or their approach to processing it. More than 50% of the lawyers responding to this question in the mail survey found expert testimony to have the greatest bearing on their acceptance of a case. Of the lawyers personally interviewed, expert testimony was also considered very important.

The statute of limitations was also identified as a significant issue. It is noted that 20.5% of the Selected Sample responding in the mail survey raised statute of limitations as an important issue determining acceptance of a case and 12.5% raised it as important to processing a case. In the personal interviews of these more sophisticated practitioners, 34.4% of the plaintiffs' lawyers and 14.3% of the defense lawyers raised the statute of limitations as significant to acceptance of a case and 16% raised it as significant to processing the case.

The above results and the percentages associated with other issues, e.g., informed consent, *respondeat superior*, and *res ipsa loquitur*, demonstrate a surprising degree of similarity with the relative reliance on these issues or doctrines in the analysis of appellate decisions. This is true in spite of the fact that the opinion survey of lawyers is not directly comparable with the analysis of appellate decisions. While the sample was admittedly small, it is reasonable to conclude that the availability of certain legal doctrines is a significant factor in a lawyer's decision to accept a case and also to his approach in processing it.

The degree to which this conclusion holds is clearly

TABLE III-59.

FREQUENCY OF ISSUES SIGNIFICANT TO OUTCOME OF MALPRACTICE APPEALS (GROUPED)

Issues or Doctrines Significant to Outcome	Percentage of Cases		
	1961-1971	1950-1960	Pre-1950
Matters of Proof			
General	40.9	41.5	47.3
Standard of Care Burden of Proof Proximate Cause			
Expert Related	20.0	16.5	18.4
Need for Testimony Adverse Witness Locality Rule *Res Ipsa Loquitur*			
Bars to Action	16.5	15.4	11.3
Statute of Limitations Charitable Immunity Governmental Immunity			
Substantive Doctrines	14.4	16.0	14.5
Informed Consent Warranty/Contract Breach Statutory Cause of Action *Respondeat Superior* Contributory Negligence			
Procedural Matters	11.4	14.4	13.8

affected by the lawyer's awareness of the current state of the law concerning these doctrines in his jurisdiction. This is a function of the publicity given to changes in the law of medical malpractice and the degree to which he specializes in it.

The discovery process was perceived as an important factor, particularly to processing of cases. Of the lawyers personally interviewed, 52% of the respondents mentioned the discovery process. This is an expected finding because of the importance of the relatively recently liberalized rules concerning discovery, which allow for obtaining access to records, for taking depositions, and for interrogratories and other formal liberalized procedures for obtaining facts relevant to the case by process of the court. Because discovery is rarely an issue on appeal, it does not show up as a major issue in the analysis of appellate cases.

The relatively large percentage of personal interview respondents citing *res ipsa loquitur* can be explained by the fact that the respondent was asked about *res ipsa* if he did not mention it. The majority of those who mentioned *res ipsa* as important volunteered that they would prefer not to base a case solely on it.

Applicability of Key Doctrines by State

The key legal doctrines, rules, and statutes that bear on the processing or outcome of malpractice cases do not apply uniformly in all states. Hence the applicability of certain doctrines in a particular state can influence the volume of cases in that state as well as their outcomes.

A substantial effort was undertaken to identify the applicability of the key doctrines in each of the 50 states. Table III-62 presents a summary that simply indicates if the rule is applied or not applied (rejected) in each state.

A more complete presentation is contained in Appendix B, with approximate dates for the onset and demise of each doctrine in each state. Due to the manner in which cases are indexed and to the difficulty in determining whether a doctrine is being rejected or merely distinguished, the dates identifying the earliest cases are not authoritative.

In the case of the locality rule, an (E), for "expanded," is indicated if it has been relaxed to include "similar localities or communities."

It will be noted in Table III-62 that such restrictive doctrines as charitable immunity and governmental immunity have been rejected in 40 and 27 states, respectively. Although *res ipsa loquitur* is available in 37 states, it has been applied successfully by a plaintiff in a malpractice action and reported as upheld in an appellate case in only 34 states. The discovery rule or the doctrine of fraudulent concealment has been used to relax the strict barrier of the statute of limitations in 36 states, and the locality rule has been expanded or rejected in 22 states.

Impact of Doctrines, Rules, and Statutes on Outcome of Appeals

This section deals with the difficult analytical problem of how the application of a particular doctrine influences the outcome of appellate cases. It will be seen that the application of certain doctrines will result in a higher than average percentage of plaintiff wins. It will also be seen that the percentage of plaintiff wins both at the trial and appeal levels has definitely changed over time.

It is important at this juncture to emphasize again that only reported appellate decisions are dealt with here. Where a trial result is noted, the reference is to the indication of what happened in a lower court, as reported in the appellate decision.

Outcomes Versus Time

Table III-63 summarizes the outcomes of the entire population of malpractice appeals in terms of which party won at the trial level and the result on appeal. The sample data have been weighted by the sampling factors to project

TABLE III-60.

DOCTRINES WHICH BEAR ON ACCEPTANCE OF CASES

		Selective Survey			National Survey
		Mail Survey	Personal Interviews		Mail Survey
	No. answering Question	Plaintiff 44 Defendant 3	Plaintiff 61 Defendant 14		Plaintiff 15 Defendant 1
		% Plaintiff	% Plain.	% Def.	% Plaintiff
Expert Testimony					
Expert Testimony—need for		56.8	24.6		56.3
Expert Testimony—adverse witness			6.6		
Locality Rule		4.5	3.3	7.1	6.7
Res Ipsa Loquitur		4.5	31.1	28.6	
Statutory Bar					
Statute of Limitations		20.5	34.4	14.3	6.7
Charitable Immunity			6.6	7.1	
Governmental Immunity		2.3			
Matters of Proof—General					
Standard of Care		4.5	3.3	14.3	
Burden of Proof		2.3	3.3		
Proximate Cause		2.3	1.6		6.7
Discovery		6.9	21.3		6.7
Substantive Doctrines					
Consent/Informed Consent		2.3	16.4	21.4	6.7
Warranty/Contract Breach					
Respondeat Superior			5.0		
Contributory Negligence		2.3			
Exclusive Control			1.6	7.1	
Wrongful Death Statute				7.1	

TABLE III-61.

DOCTRINES WHICH BEAR ON PROCESSING OF CASES

	Selective Survey		National Survey
	Mail Survey	Personal Interviews	Mail Survey
No. answering Question	Plaintiff 24 Defendant 4	Plaintiff 25 Defendant 4	Plaintiff 8 Defendant 1
	% Plaintiff	% Plaintiff	% Plaintiff
Expert Testimony			
Expert Testimony—need for	58.3	12.0	75.0
Expert Testimony—adverse witness	8.3	4.0	
Locality Rule	4.2	20.0	
Statutory Bar			
Statute of Limitations	12.5	16.0	
Charitable Immunity		8.0	
Governmental Immunity			
Matters of Proof—General			
Standard of Care	12.5		
Burden of Proof			12.5
Proximate Cause			
Discovery	16.7	52.0	
Substantive Doctrines			
Consent/Informed Consent	4.2	4.0	
Warranty/Contract Breach		8.0	
Procedural Matters			
Instructions		8.0	
Procedural Issues		8.0	

back to population totals. The columns present trial results and the rows show appeal results. Examining the column totals, it is noted that, of the 3,717 total appellate cases, the plaintiff won 1,491 or 40.1% of the cases at trial and the defendant won 2,226 or 59.9% of the cases at the trial level. The row totals note that the plaintiff won 1,752 or 47.1% and the defendant won 1,965 or 52.9% of the cases on appeal. The plaintiff wins on appeal are the sum of 852 plaintiff trial wins affirmed on appeal and 900 defendant trial wins reversed on appeal.

It is important to understand that, at this stage of knowledge about appellate practices, the trial wins are merely indicative of who appealed the case and not an estimate of the percentage of cases in which either party historically prevails at the trial level. If appeals that are based on purposted errors of law at trial could be shown to be a random phenomenon and an appeals-to-trial ration can be established, however, then appellate decisions might become useful as an easily measurable indicator of medical malpractice trials volume. Since the defendant won in 59.9% of the appeal cases at trial, the plaintiff obviously brought approximately 59.9% of the appeals.

Trial and Appellate Results Versus Time

Table III-64 summarizes the various outcomes of the reported appellate decisions for different time intervals. Below is an explanation of what is included in each column on the tables that follow:

Column 1: For Plaintiff, Appeal Affirmed. This column includes all of those cases that were decided at the trial level for the plaintiff and were affirmed on appeal. That is, they are plaintiff appeal wins. These appeals are generally brought by the defendant (except in the few cases where the plaintiff appeals because he is dissatisfied with the amount of the award).

Column 2: For Plaintiff, Appeal Reversed. These cases were decided for the plaintiff at the trial level and reversed on appeal, making defendant appeal wins. These appeals are also brought generally by the

TABLE III-62.

APPLICABILITY OF KEY DOCTRINES (ALL STATES)

NOTE: "A" = Applied "R" = Rejected "E" = Expanded	Statute of Limitations—Discovery Rule or Fraudulent Concealment	Locality Rule	Res Ipsa Loquitur	Respondent Superior—Hospital	Charitable Immunity	Informed Consent	Governmental Immunity
Alabama	A	A	A	R	R		A
Alaska							R
Arizona	A	A	A		R	A	R
Arkansas	A	A		A	A		R
California	A	E	A	A	R	A	R
Colorado	A	A		A	A	A	A
Connecticut	A	A	A	R	R		R
Delaware		A		A	A	A	
Florida	A	E	A	A	R	A	R
Georgia		E	A	R	A		R
Hawaii	A		A	A	R	A	R
Idaho	A	A	A	A	R		R
Illinois	A	A	A	A	R		A
Indiana	A	A	A	R	R	A	A
Iowa		E	A	A	R	A	R
Kansas		A	A	R	R	A	R
Kentucky	A	E	A	A	R		R
Louisiana	A	A	A	R	A	A	A
Maine		A			R		A
Maryland	A	A			R		A
Massachusetts	A	R	A		R		A
Michigan	A	E	A	A	R	A	A
Minnesota	A	E	A	A	R	A	R
Mississippi	A	A	A	A	R		R
Missouri	A	A	A	A	R		
Montana	A	A	A	A	R	R	R
Nebraska	A	A		A	R		
Nevada		A			A		R
New Hampshire		E		A	R		R
New Jersey	A	E	A		R	A	A
New Mexico		A	A			A	R
New York	A	E	A	A	R	A	R
North Carolina		E	A	A	R	A	R
North Dakota	A	E			R		A
Ohio	A	E	A	A	R		A
Oklahoma	A	E	A	A	R		R
Oregon	A	E	A	A	R	A	A
Pennsylvania	A	E	A	A	R	A	A
Rhode Island	A	A	A	A	R		R
South Carolina		A			A		A
South Dakota	A	A		A		A	A
Tennessee	A	A	A	A	R	A	R
Texas	A	E	A	A	A	A	A
Utah	A	E	A	A	R		A
Vermont	A	A			R		R
Virginia		A	A	A	A		A
Washington	A	E	A	A	R	A	R
West Virginia		E		A	R		A
Wisconsin		E	A	A	R		R
Wyoming			A		R	A	A
District of Columbia	A	A	A	A	R		R

TABLE III-63.

OUTCOME OF TOTAL APPELLATE CASES

Appeal Outcome	Trial Outcome					
	For Plaintiff		For Defendant		Totals	
	No.	Percent	No.	Percent	No.	Percent
For Plaintiff	852	22.9	900	24.2	1752	47.1
For Defendant	639	17.2	1326	35.7	1965	52.9
Totals	1491	40.1	2226	59.9	3717	100.0

TABLE III-64.

TRIAL AND APPELLATE RESULTS (APPEALED CASES)

	1		2		3		4		5		6		7	
	Outcome of Case													
Years	For Plaintiff Appeal Affirmed		For Plaintiff Appeal Reversed		For Defendant Appeal Affirmed		For Defendant Appeal Reversed		Total Plaintiff Trial Wins		Total Plaintiff Appeal Wins		Total Cases Appealed	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Pre 1910	78	44.8	54	31.0	24	13.8	18	10.3	132	75.9	96	55.2	174	100.0
1910-39	372	29.4	336	26.5	348	27.5	210	16.6	708	55.9	582	46.0	1266	100.0
1940-44	54	23.1	30	12.8	78	33.3	72	30.8	84	35.9	126	53.8	234	100.0
1945-49	24	19.0	6	4.8	36	28.6	60	47.6	30	23.8	84	66.7	126	100.0
1950-54	57	22.1	30	11.6	120	46.5	51	19.8	87	33.7	108	41.9	258	100.0
1955-59	42	13.9	45	14.9	120	39.6	96	31.7	87	28.7	138	45.5	303	100.0
1960-64	69	17.6	51	13.0	180	45.8	93	23.7	120	30.5	162	41.2	393	100.0
1965-69	129	16.9	69	9.0	336	43.9	231	30.2	198	25.9	360	47.1	765	100.0
1970-71	27	13.6	18	9.1	84	42.4	69	34.8	45	22.7	96	48.5	198	100.0
Totals	852	22.9	639	17.2	1326	35.7	900	24.2	1491	40.1	1752	47.1	3717	100.0

defendant.

Column 3: For Defendant, Appeal Affirmed. These cases were decided for the defendant at the trial level and affirmed on appeal. They are defendant appeal wins. These appeals are generally brought by the plaintiff, who lost at the trial level.

Column 4: For Defendant, Appeal Reserved. These cases were decided for the defendant at the trial level and reversed on appeal, resulting in plaintiff appeal wins. These appeals, of course, are also brought by the plaintiff.

Column 5: Total Plaintiff Appeal Wins. The cases included in this column are those in which the trial court's decision for the plaintiff was affirmed on appeal

(Column 1), plus those cases decided for the defendant at the trial level reversed on appeal (Column 4) in favor of the plaintiff. The percentages are computed as

$$\frac{\text{Column } 1 + 4}{\text{Column } 1 + 2 + 3 + 4}$$

Column 6: Total Plaintiff Trial Wins. This column includes the number and percentage of cases that were decided for the plaintiff at the trial level and were either affirmed or reversed. The percentages are computed as

$$\frac{\text{Column } 1 + 2}{\text{Column } 1 + 2 + 3 + 4}$$

Column 7: Total Malpractice Appeal Cases. This column represents the total of all cases appealed. It is the sum of Columns 1 + 2 + 3 + 4.

It is important to note that, while the average percentage of plaintiff appeal wins has remained relatively constant over the years, the percentage of appellate cases that had been decided for the plaintiff at the trial level has dropped significantly in the last several decades. Since the plaintiff only won 22.7% of the appealed cases at trial in 1970-1971 (Column 5), he lost 77.3%, and hence was the moving party in essentially this percentage of the appeals. This compares with the 1910-1939 era in which the plaintiff won 55.9% of the appealed cases at the trial level, and hence the defendant brought the majority of the appeals. In substance, the plaintiff is currently the moving party more than twice as frequently as he was between the turn of the century and 1940, but he is winning all appeals with about the same frequency.

From the trend toward a lower percentage of plaintiff wins at the trial level (as noted from appellate cases), it may not necessarily be inferred that the plaintiff is winning a smaller percentage of cases at the trial level or in the claims settlement process. It may be that defense attorneys settle any cases that they believe have a chance of going to jury trial or that they at least offer settlement in such cases. Further, a significant percentage of cases decided in favor of the plaintiff at the trial level and then appealed by the defendant may be settled after the appeal has been filed but before the appellate trial takes place.

Trial and Appellate Results Versus Legal Doctrines

Table III-65 shows the various outcomes over time of appellate decisions where a particular doctrine was found to be most significant to the outcome. It may be noted that the time intervals are different from those shown in Table III-64. The data were tabulated both in five-year intervals and in the groupings shown in Table III-65. The five-year intervals were used primarily in plotting various graphs, whereas the breakdowns of pre-1950, 1950-1960, 1961-1971, and 1950-1971 are presented only in table form.

Looking at the groupings of doctrines, it will be found that, with the exception of the group entitled "Bars to Action," the win/loss ratios compare closely with the win/loss percentages for all appellate cases during these time periods. A discussion of the impact of such rules and doctrines as statute of limitations and charitable immunity will be provided in the following paragraphs.

Figure III-6 depicts graphically the change in percentage outcome of appellate cases over time, both of the trial results reported and the final outcome on appeal. Indicated on the graph are major events that should presumably influence future outcomes, such as the onset or demise of key doctrines in major states, and the adoption of liberal rules of procedure patterned after those used by the federal courts.

Statute of Limitations

Where the statute of limitations was the most significant issue in an appellate decision, it typically involved the granting by the court of a motion by the defendant to dismiss at the trial level, whereupon the plaintiff appealed. This explains why the percentage of plaintiff wins at the trial level is so low (14.3% in 1961-1971). The appeal result showing the plaintiff winning more than 50% of the cases indicates that such doctrines as fraudulent concealment or the "discovery rule" were applied.

Table III-66 compares the number and outcomes of cases involving the statute of limitations in 15 states having the largest number of medical malpractice appeals. These 15 states account for 59% of all malpractice appeals in which there was a key issue reported and approximately 53% of the statute of limitations cases. It is interesting to note that, in many states, the plaintiff never won at the trial level but won on appeal (California, Illinois, Kansas, Louisiana, Texas, and Washington). This illustrates that the fraudulent concealment doctrine or the discovery rule is initially rejected by the trial courts (which are reluctant to overturn existing law), but later adopted by the appellate courts or the legislature. Once the rule is established in a particular state, generally it is clearly stated and very few cases concerning it show upon appeal.

Expert Testimony

It may be noted in Table III-65 that the subtotal for the group of doctrines related to expert testimony shows that plaintiff wins at trial and appeal closely follow the totals for all cases. This is not unexpected, since expert testimony is a major element for all cases. The table also shows that only 9.1% of the appellate cases in which the locality rule was the major issue had been decided in favor of the plaintiff at the trial level. It thus allows one to infer that more than 90% of the appeals in which the locality rule was the basic issue were brought by the plaintiff. The 63.6% plaintiff wins on appeal during the 1961-1971 period suggests that this was the timeframe during which the appellate courts began to apply an expanded locality rule by changing the standard of care to that exercised by physicians, generally, in the same or similar localities or communities.

Table III-67 compares the frequency and outcomes of appellate cases involving the need for expert testimony in selected states. California stands out with more than 72%

TABLE III-65.

IMPACT OF DOCTRINES ON OUTCOMES OF APPEALS

	1961-1971		1950-1960		Pre-1950	
	Trial Pl.Win	Appeal Pl.Win	Trial Pl.Win	Appeal Pl.Win	Trial Pl.Win	Appeal Pl.Win
Matters of Proof	25.6	43.8	33.3	43.8	52.8	48.3
General	26.2	40.5	33.3	37.2	51.5	44.8
Standard of Care	29.0	44.9	40.0	44.0	45.2	42.9
Burden of Proof	23.1	34.6	30.6	30.6	54.5	48.9
Proximate Cause	28.6	42.9	36.4	27.3	44.4	33.3
Expert Related	25.6	51.2	32.3	58.1	53.8	53.8
Need for Testimony	20.0	50.0	33.3	66.7	54.5	51.5
Locality Rule	9.1	63.6	0.0	0.0	50.0	64.3
Adverse Witness	25.0	75.0	0.0	0.0	0.0	0.0
Res Ipsa Loquitur	36.4	51.5	40.0	66.7	50.0	50.0
Bars to Action	14.7	47.1	17.2	48.3	31.3	40.6
Statute of Limitations	14.3	53.1	7.7	53.8	23.8	47.6
Charitable Immunity	30.8	30.8	28.6	71.4	60.0	30.0
Governmental Immunity	0.0	28.6	22.2	22.2	0.0	0.0
Substantive Doctrines	23.7	49.2	30.0	50.0	63.4	51.2
Informed Consent	21.1	47.4	20.0	0.0	66.7	66.7
Warranty/Contract Breach	18.2	72.7	33.3	33.3	100.0	0.0
Statutory Cause of Action	0.0	40.0	0.0	66.7	75.0	50.0
Respondeat Superior	35.3	29.4	25.0	66.7	65.0	50.0
Contributory Negligence	50.0	75.0	33.3	66.7	66.7	50.0
Procedural Matters	25.5	53.2	44.4	37.0	76.9	61.5
Total	25.3	45.5	31.9	44.7	53.7	50.5

of the appeals being decided in favor of the plaintiff. As will be noted in Table III-68, which follows, the doctrine of *res ipsa loquitur* was applied in nearly half of these cases. Michigan had the second largest number of cases in which expert testimony was the major issue. The plaintiff won only 28.6% of his appeals in either timeframe. In examining these cases closely, note that the Michigan appeals courts refused to apply *res ipsa* until 1968, and strictly applied the locality rule until 1971, when it relaxed the requirement as to specialists.

Res Ipsa Loquitur

Looking again at Table III-65, one may note that, with respect to appellate cases in which *res ipsa loquitur* was the most significant legal doctrine at issue, plaintiffs were most successful during the 1950-1960 timeframe. The table also shows that where res ipsa is a major issue, the overall plaintiff success on appeal has been substantially higher than the average for all cases.

In Table III-68, the importance of *res ipsa* is compared for a number of key states. It is to be noted that 66 of the 117 *res ipsa* cases in these 15 states are from California.

It is interesting to note that significant increases in *res ipsa* application in California occurred in the post-1950 period, closely following the decision of *Ybarra vs. Spangard*, 154 P.2d 687 (1944). In this case, Mr. Ybarra awoke from abdominal surgery with a paralyzed arm. It was held that injury to this previously healthy and remote portion of the body raised an inference of negligence. The evaluation of the doctrine of *res ipsa loquitur* in California has been characterized by one commentator as expanded to apply situations where, because it is rare that trouble would develop following a given procedure or treatment, an inference that someone has been negligent arises if trouble, in fact, develops.

It is also interesting to note that the sample did not identify any cases in which *res ipsa* was significant to a plaintiff appeal win after 1950 in Kansas, Michigan, Minnesota, Missouri, Ohio, Pennsylvania, and Texas. This, of course, is also true for many of the other states not included on this chart.

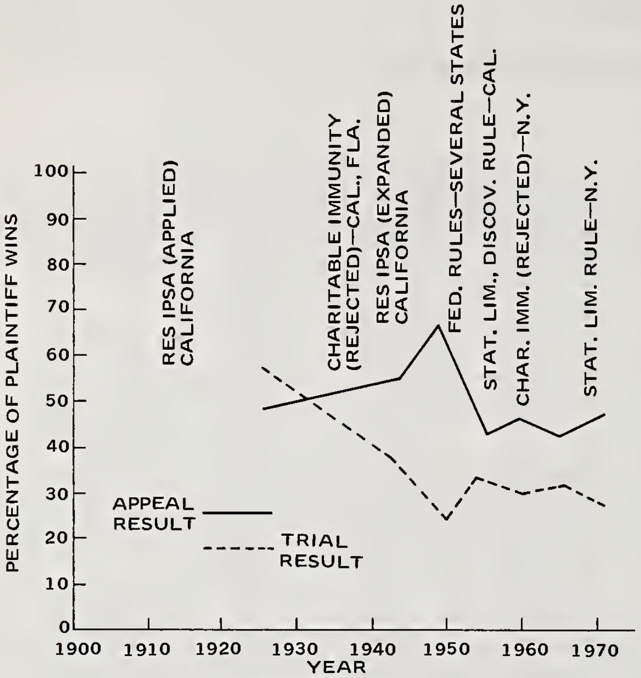


FIGURE III-6
PERCENTAGE OF OUTCOMES OF APPELLATE CASES IN FAVOR OF PLAINTIFF—AT TRIAL AND APPEAL LEVELS

While New York accounts for the second largest number of malpractice appeals in this sample, *res ipsa* has been a very minor issue in that state.

One possible explanation for the relatively infrequent reliance (outside of California) on *res ipsa loquitur* is that, in addition to the broadened view of the law in California, there must be an appropriate fact situation to which it applies. *Res ipsa* relies upon the axiom, "but for negligence, this could not have happened." In most medical situations, this is a difficult proposition to sustain for untoward effects or medical accidents are possible without negligence.

Matters of Proof

Table III-69 summarizes the outcomes in the selected 15 states for all doctrines relating to proof. This affords a larger sample size in each state and eliminates many of the problems in selecting the most significant issue in a case. Looking at the appeal result column for 1950-1971, note that the plaintiff has historically won 50% or more of these appeals in California, Georgia, Kansas, Ohio, and Washington. The reverse is true in Lousiana (16.7%), Minnesota (16.7%), New York (32.1%), Pennsylvania (14.3%), and Texas (28.6%).

It is interesting to compare the dates of onset or rejection of certain of these liberal doctrines in these two sets of states (Table III-70, A and B).

Charitable Immunity

Because the doctrine of charitable immunity has been rejected in most states, it has become an issue found only infrequently in malpractice appeals in recent years. Looking back at Table III-65, note that prior to 1950 the plaintiff won at trial in 60% of the cases and ended up with an appeal win in only 30% of the cases. This means that the defendant brought the appeal in most cases and was reasonably successful. During the 1950-1960 timeframe, the plaintiff generally brought the appeal and he was successful in 71.4% of the cases. This later timeframe is the one in which many states were beginning to reject the old doctrine of charitable immunity.

Battery and the Doctrine of Informed Consent

As noted in Table III-71, almost all of the cases involving informed consent have occured since 1950. In fact, the majority occurred in the last decade.

The relatively infrequent use of informed consent correlates with another finding which shows that battery was brought as the type of action in only 3.9% of all the cases studied. One rationale for the infrequent use of battery as a basis for malpractice actions is that in order to sustain a *prima facie* case in battery there must be a lack of consent and an injury. In addition, expert testimony generally is required to establish that the information furnished by which consent was given was inadequate.

Respondeat Superior

Table III-65 showed that plaintiffs won a much smaller percentage of the appeals in which the doctrine of *respondeat superior* was the most significant issue during the 1961-1971 timeframe than they did in the years before 1961. The percentage of plaintiff wins dropped from 66.7% in 1950-1960 to 29.4% in 1961-1971. The decline correlates, somewhat, with a similar drop in plaintiff win ratio for appeals in which charitable immunity was the most significant issue. In these cases the percentage of plaintiff wins dropped from 71.4% in 1950-1960 to 30.8% in 1971. Looking at Table III-72, it is noted that the plaintiff won in 50% of the appeals in which *respondeat superior* was the most significant issue in both the pre-1950 and recent periods in the 15 states with the largest number of malpractice cases. Thus, the experience in the selected states differs from the national result for the recent period.

Influence of Key Doctrines on Initiation of Cases

In this section, the objective was to correlate, if possible, the onset of a new doctrine or the demise of a restrictive doctrine with the increase in malpractice appeals. Further, an attempt was made to correlate such existing data as number of hospital beds, number of patients, number of doctors, and number of lawyers with the volume of appeals.

Limitation to Appellate Decisions

It is important to emphasize once again that this study is based only on the sample of appellate decisions.

The volume and outcome of appellate cases will depend, in part, on such aspects as the size of the verdict, the method by which the attorneys for both sides are com-

TABLE III-66.

NUMBER OF APPELLATE CASES AND OUTCOMES IN WHICH STATUTE OF LIMITATIONS WAS MOST SIGNIFICANT ISSUE (SELECTED STATES)

State	Total No. Malpractice Appeals	No. of Cases (all years)	1950-1971			Pre 1950		
			No. Cases Significant	Trial % Pl	Appeal % Pl	No. Cases Significant	Trial % Pl	Appeal % Pl
California	378	21	9	0.0	66.7	12	0.0	50.0
Florida	138	21	21	14.3	85.7	0	0.0	0.0
Georgia	126	3	3	100.0	0.0	0	0.0	0.0
Illinois	105	6	6	0.0	50.0	0	0.0	0.0
Kansas	96	18	12	0.0	25.0	6	0.0	100.0
Louisiana	129	15	15	0.0	26.0	0	0.0	0.0
Michigan	129	3	3	0.0	20.0	0	0.0	0.0
Minnesota	126	6	0	0.0	0.0	6	100.0	100.0
Missouri	123	6	0	0	0.0	6	0.0	0.0
New Jersey	87	0	0	0	0.0	0	0.0	0.0
New York	327	36	12	50.0	75.0	24	25.0	75.0
Ohio	81	9	9	33.3	0.0	0	0.0	0.0
Pennsylvania	69	0	0	0.0	50.0	0	0.0	0.0
Texas	129	3	3	0.0	100.0	0	0.0	0.0
Washington	150	18	6	0.0	0.0	12	0.0	50.0
Subtotal (above states)	2,193	165	99	15.2	45.5	66	18.2	63.6
National	3,717	312	186	12.9	53.2	126	23.8	47.6

pensated and other subtle factors.

The defendant's insurance company may be more likely to appeal a large verdict, particularly when the cost of an appeal is relatively small compared with the cost of paying the verdict (see III.F.).

The greater number of plaintiff appeals (meaning the plaintiff lost at the trial court) may also correlate with the fact that generally when the plaintiff loses at trial, his attorney obtains no fee. This contingent fee system may operate to increase the likelihood that the plaintiff's attorney will file for an appeal and go all the way if he is not offered a reasonable settlement.

Increase in Volume of Appeals

As Figure III-7 displays, the number of reported medical malpractice appellate decisions has more than trebled over the past two decades, far outpacing the almost linear growth of lawyers or doctors. However, the several orders-of-magnitude differences between these two dimensions renders their comparison almost meaningless.

The total number of written opinions and appeals decided in the state courts of last resort were found in the literature for the years 1951, 1952, 1955, and 1961. These reported data required pretotal interpretation due to the lack of standard court reporting systems and classifications. It was believed necessary to have these totals in order to present the number of malpractice cases at this level in terms of the total output of the courts rather than as a number of cases. The comparable data for post-1961 are not available.

Since some estimate of the total number of written opinions was required for the post-1961 period, in which the absolute number of medical malpractice decisions increased so rapidly, an estimate of the appeals decided and opinions written in 1971 was made based on a projection of the known trends in New York and California. It was determined that there had been no changes in the court structure that would cause an unexpected trend in the estimation. The national totals for those years in which state totals were available were studied and no states were found to dominate the totals. The estimation of the increase in total national appeals decided was then an extrapolation of the known increase from the 1955-1961 time period to the 1961-1971 time period, based on increases in the two states. These estimates may be considered high since New York and California would be expected to experience a greater case increase than less urban states. The percent of total appellate cases that are medical malpractice appeals is shown to increase only slightly, even when based on this admittedly high estimate.

By examining these comparative statistics of judicial activity in the state courts of America, it can be shown that a medical malpractice decision in an appellate court is indeed a rare phenomenon—even in those states that have the greatest absolute number of appealed medical malpractice cases.

Two bases of comparison showing the total level of opinions written and appeals decided are presented in the left portion of Figure III-8. The right side of the figure shows that medical malpractice appellate decisions occupy less than 1% of all opinions written in the highest state courts of America.

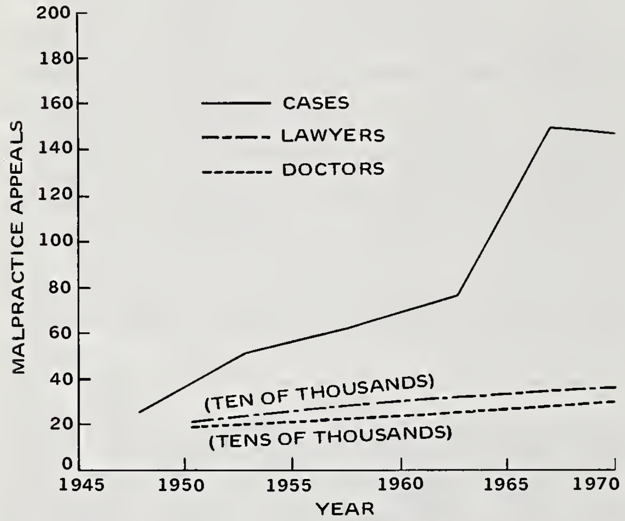


FIGURE III-7
MALPRACTICE APPEALS VS. LAWYERS
AND DOCTORS—NATIONAL

Although the number of percentage of appellate decisions may have increased slightly over the last two decades in the highest state courts, there are indications that medical malpractice appellate decisions in New York and California are occupying an ever smaller percentage of a miniscule part of the workload of the courts in these two states. Figure III-9 shows the trends in California and Figure III-10 illustrates the trends in New York. For these jurisdictions, a least-squares fit of the reported data indicates that, for the highest state court of California and its intermediate appellate courts, a steady decline in the relative importance of medical malpractice appeal decisions as a percentage of total opinions has taken place between 1950 and 1970.

In New York (Figure III-10), the percentage of medical malpractice appeals is a constant three-tenths of one percent. Although only two data points are available for New York's intermediate appellate courts, it may be inferred that the percentage of opinions written is a small (five to seven percent) percentage of total opinions, with a downward trend (from the only data available).

Influence of Doctrines on Volume of Appellate Cases

Figure III-11 illustrates the national growth in the number of malpractice appeals with an indication of the onset of such significant events as the application of federal rules of civil procedures, the expansion of the application of *res ipsa loquitur*, the relaxation of the locality rule, the abolition of charitable immunity and the application of the discovery rule or fraudulent concealment in statute of limitations cases. It is impossible to draw any cause and effect conclusions from this chart. However, many of the significant changes which tend to benefit the plaintiff occurred prior to the increase in the rate of growth of malpractice appeals, which started in 1960.

Variations in California and New York

Figure III-12 presents the growth of malpractice cases in California as compared to other factors. There is an apparent relationship between the expansion of the *res ipsa* doctrine in 1944 and the increase in total appellate cases after that point.

Figure III-13 presents the same data for New York. There, the increase in the number of malpractice appeals each year is growing at a faster rate than in California, but the growth did not begin until approximately 1960. Several of the legal doctrines which inhibited or barred recovery were abolished or relaxed in the 1950-1960 timeframe. One example is the application of the "discovery rule" in a statute of limitations situation in 1952.

Class of Defendant, Type of Illness Treated and Other Factors

This section presents summary data from the total sample of malpractice appeals as well as reported trial opinions on various characteristics of the parties to a case, the types of injuries, the awards and other parameters.

TABLE III-67.

NUMBER OF APPELLATE CASES AND OUTCOMES IN WHICH AN EXPERT TESTIMONY RELATED DOCTRINE WAS MOST SIGNIFICANT ISSUE (SELECTED STATES)

State	Total No. Malpractice Appeals	No. of Cases (all years)	1950-1971			Pre 1950		
			No. Cases Significant	Trial % Pl	Appeal % Pl	No. Cases Significant	Trial % Pl	Appeal % Pl
California	378	135	66	45.5	72.7	69	39.1	73.9
Florida	138	18	18	0.0	66.7	0	0.0	0.0
Georgia	126	18	6	50.0	100.0	12	0.0	0.0
Illinois	105	15	3	0.0	0.0	12	50.0	50.0
Kansas	96	15	9	33.3	33.3	6	100.0	100.0
Louisiana	129	12	12	75.0	50.0	0	0.0	0.0
Michigan	129	63	21	14.3	28.6	42	71.4	28.6
Minnesota	126	12	6	0.0	0.0	6	100.0	100.0
Missouri	123	30	12	25.0	25.0	18	100.0	66.7
New Jersey	87	18	6	0.0	50.0	12	0.0	50.0
New York	327	21	3	100.0	0.0	18	33.3	66.7
Ohio	81	9	9	0.0	66.7	0	0.0	0.0
Pennsylvania	69	12	6	0.0	0.0	6	0.0	0.0
Texas	129	6	6	0.0	100.0	0	0.0	0.0
Washington	150	27	15	40.0	80.0	12	100.0	50.0
Subtotal (above states)	2,193	411	198	28.4	56.7	213	57.1	54.3
National	3,717	651	339	27.4	53.1	312	53.8	53.8

Class of Defendant

Table III-73 shows the breakdown of defendants both by type of individual and by type of institution. It is clear that surgical specialists account for the largest volume of those appeals involving individual defendants (56.2 percent in the 1950-1971 timeframe) followed by general practitioners (28.4 percent in the 1950-1971 timeframe.) The outcomes do not vary substantially from one class of individual to another. It is interesting to note that the percentage of appellate cases involving dentists has dropped sharply from 14.1 percent prior to 1950 to 5.6 percent after 1950.

General hospitals account for the overwhelming majority of appeals cases involving institutions (82.8 percent after 1950). There has also been a modest increase in the percentage of appeals involving suppliers or manufacturers of hospital equipment, drugs, and other supplies after 1950, but the number of cases is still quite small. The only variation in outcomes among different classes of defendants is that for psychiatric hospitals. The bulk of appeals in the cases involving psychiatric hospitals were brought by the defendant (since the plaintiff won at trial) and reversals were often obtained. The final appeal outcomes for psychiatric hospitals shows the plaintiff winning 28.6 percent of the cases after 1950 as compared to an overall plaintiff appeals win record of 44.5 percent for all cases involving institutions.

UNITED STATES
Highest State Courts

FIGURE III-8
TOTAL APPELLATE ACTIVITY IN THE HIGHEST STATE COURTS AND PERCENTAGES OF MEDICAL MALPRACTICE APPELLATE ACTIVITY

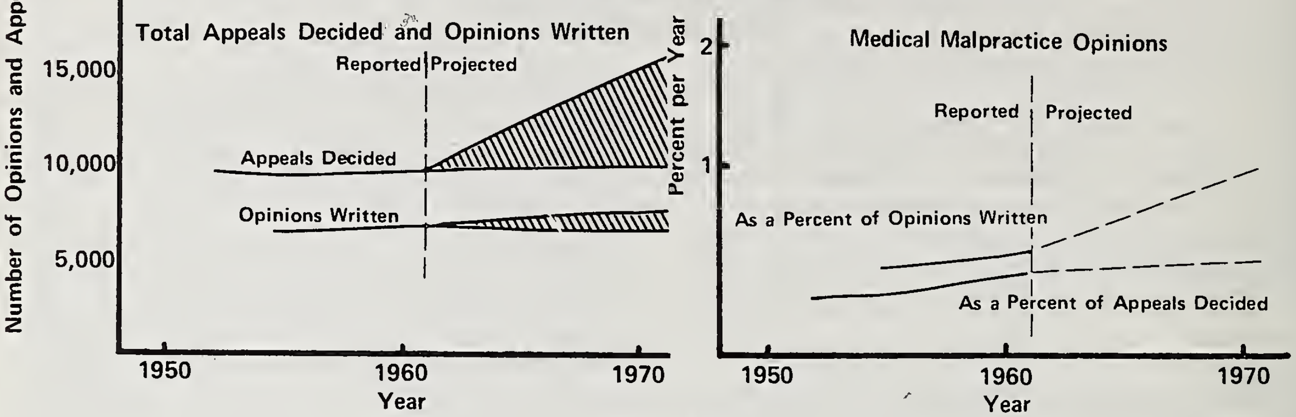


TABLE III-68.

NUMBER OF APPELLATE CASES AND OUTCOMES IN WHICH *RES IPSA LOQUITUR* WAS MOST SIGNIFICANT ISSUE(SELECTED STATES)

State	Total No. Malpractice Appeals	No. of Cases (All years)	1950-1971			Pre 1950		
			No. Cases Significant	Trial % Pl	Appeal % Pl	No. Cases Significant	Trial % Pl	Appeal % Pl
California	378	66	60	35.0	75.0	6	100.0	100.0
Florida	138	3	3	0.0	100.0	0	0.0	0.0
Georgia	126	9	3	100.0	100.0	6	0.0	0.0
Illinois	105	6	6	100.0	100.0	0	0.0	0.0
Kansas	96	0	0	0.0	0.0	0	0.0	0.0
Louisiana	129	6	6	100.0	50.0	0	0.0	0.0
Michigan	129	3	3	0.0	0.0	0	0.0	0.0
Minnesota	126	6	0	0.0	0.0	6	100.0	100.0
Missouri	123	3	3	0.0	0.0	0	0.0	0.0
New Jersey	87	3	3	0.0	100.0	0	0.0	0.0
New York	327	3	3	100.0	0.0	0	0.0	0.0
Ohio	81	3	3	0.0	0.0	0	0.0	0.0
Pennsylvania	69	0	0	0.0	0.0	0	0.0	0.0
Texas	129	0	0	0.0	0.0	0	0.0	0.0
Washington	150	6	6	0.0	50.0	0	0.0	0.0
Sub-total (above states)	2,193	117	99	38.7	67.7	18	75.0	50.0
National	3,717	189	144	37.5	56.3	36	50.0	50.0

Number of Defendants

Table III-74 shows that 77.2 percent of the cases involved only one defendant, with 22.8 percent involving more than one defendant. A brief examination of this table for selected states showed a wide range in the percentage of cases involving only one defendant as follows:

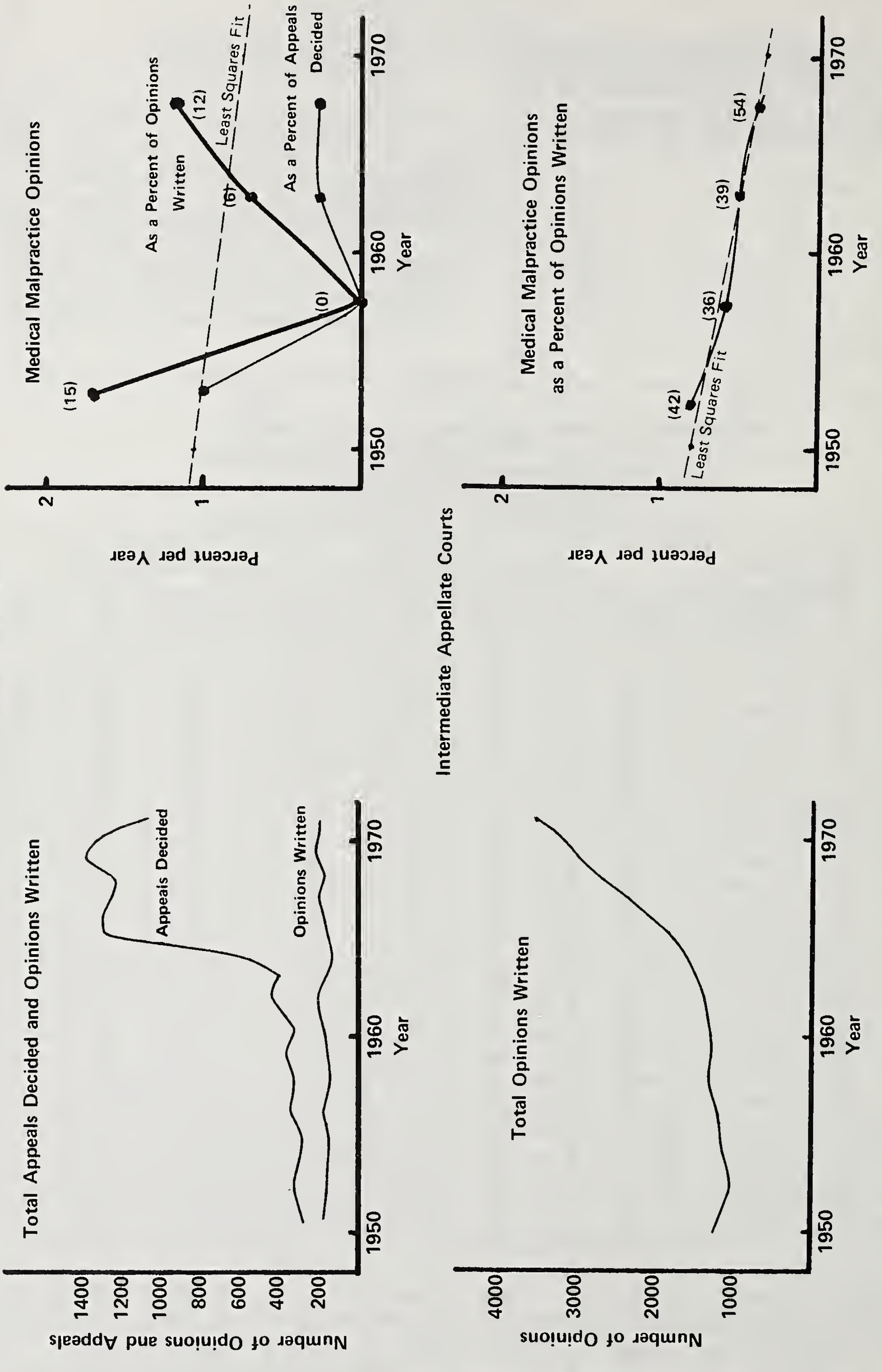
California	39.5
Colorado	75.0
Connecticut	73.0
Florida	51.5
Georgia	83.7
Indiana	90.0
Kansas	69.0
Louisiana	50.0
Massachusetts	86.7
Michigan	35.3
New Jersey	59.5
New York	64.1
Texas	58.3
Washington	53.2

With the wide use of *res ipsa* in California, it is not surprising that the majority of cases there involve more than one defendant. Since with *res ipsa* the plaintiff presumably does not know how the injury occurred or who was involved in the causal chain, he must name many persons who may be responsible as defendants. The defendants must then go forward with evidence to explain what happened to rebut the inference of negligence.

TABLE III-69.

NUMBER OF APPELLATE CASES AND OUTCOMES IN WHICH A DOCTRINE RELATED TO MATTERS OF PROOF WAS MOST SIGNIFICANT ISSUE (SELECTED STATES)

State	Total No. Maplpractice Appeals	No. of Cases (All years)	1950-1971			Pre 1950		
			No. Cases Significant	Trial % Pl	Appeal % Pl	No. Cases Significant	Trial % Pl	Appeal % Pl
California	378	234	120	40.0	60.0	114	36.8	57.9
Florida	138	78	72	25.0	45.8	6	0.0	100.0
Georgia	126	66	30	40.0	50.0	36	16.7	33.3
Illinois	105	66	24	37.5	37.5	42	57.1	42.9
Kansas	96	39	21	23.6	57.1	18	66.7	100.0
Louisiana	129	84	72	33.3	16.7	12	50.0	0.0
Michigan	129	81	33	9.1	45.5	48	62.5	37.5
Minnesota	126	78	18	0.0	16.7	60	60.0	60.0
Missouri	123	87	27	11.1	44.4	60	70.0	50.0
New Jersey	87	45	15	41.1	40.0	30	40.0	60.0
New York	327	162	84	42.9	32.1	78	46.2	46.2
Ohio	81	27	21	14.3	57.1	6	100.0	100.0
Pennsylvania	69	39	21	42.9	14.3	18	0.0	0.0
Texas	129	93	63	14.3	28.6	30	20.0	20.0
Washington	150	90	42	35.7	71.4	48	87.5	87.5
Subtotal (above states)	2,193	1,269	663	30.3	42.1	606	49.5	51.5
National	3,717	2,097	1,041	28.9	43.8	1,056	52.8	48.3



Numbers in parenthesis are number of Medical Malpractice cases per data point

FIGURE III-9
CALIFORNIA APPELLATE COURT ACTIVITY AND PERCENTAGES OF MEDICAL MALPRACTICE APPELLATE ACTIVITY

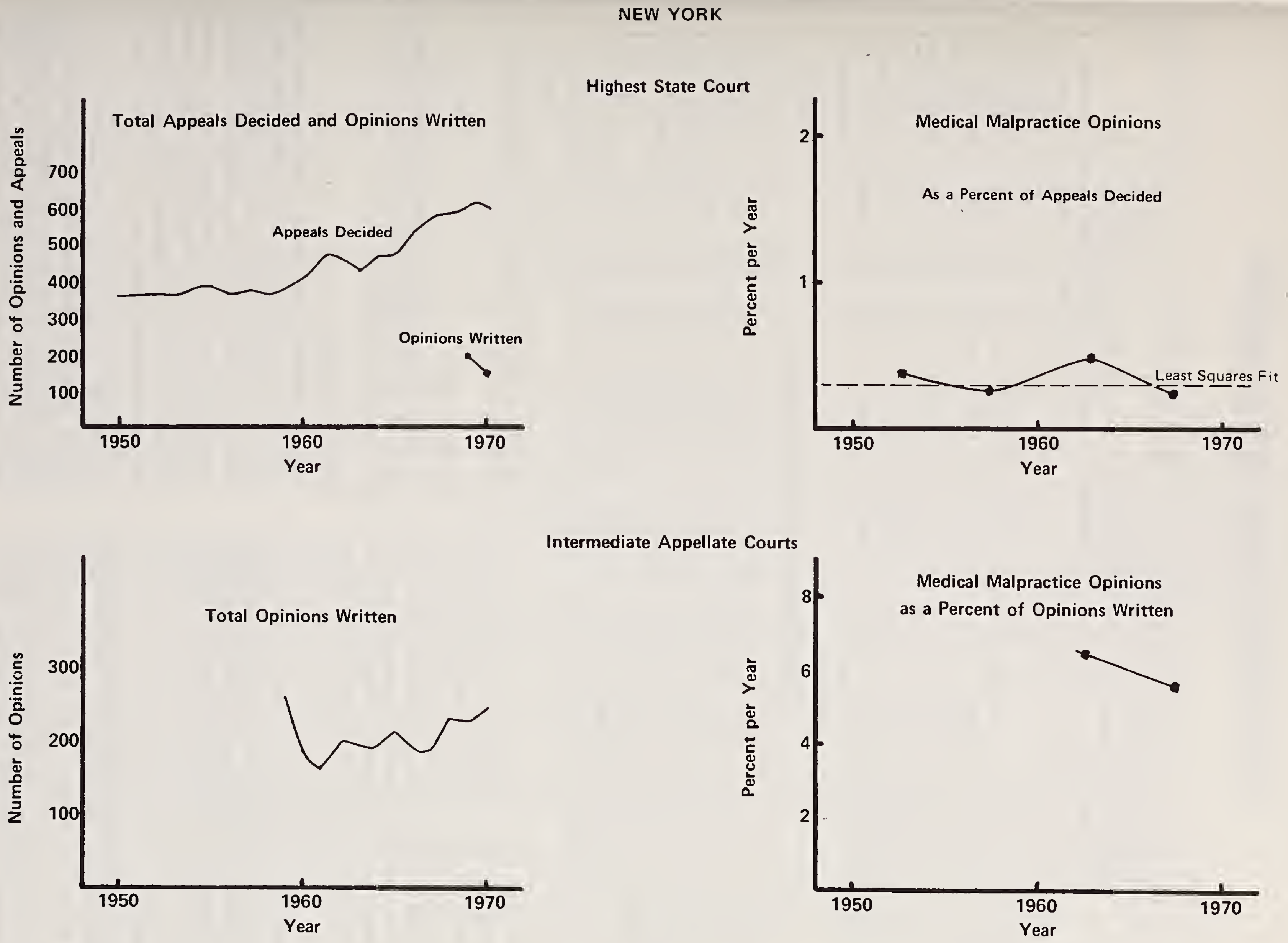


FIGURE III-10
NEW YORK APPELLATE COURT ACTIVITY AND PERCENTAGES OF MEDICAL MALPRACTICE APPELLATE ACTIVITY

TABLE III-70.

OUTCOMES vs. ONSET AND REJECTION OF KEY DOCTRINES (SELECTED STATES) 1950-1972

State	% Pl. Win (Appeal–Matters of Proof)	Federal Rules or Equivalent	Abolition of Charitable Immunity	Statute of Limitations "Discovery" Rule	*Res Ipsa Loquitur*	Locality Rule Expanded	Abolition of Governmental Immunity	Warranty Applied
(A) High Percentage of Plaintiff Appeal Wins								
California	60.0		1939	1954	1916-1944	1939	1963	1924
Georgia	50.0	1966	No	No	1970	1965	1957	1940
Kansas	57.1	1958	1954	No	1914	No	1956	1870
Ohio	57.1	1970	1956	1968	1913	1933	No	No
Washington	71.4	1967	1953	1969	1913	1967	1961	No
(B) Low Percentage of Plaintiff Appeal Wins								
Louisiana	16.7	1961	No	1934	1954	No	No	No
Minnesota	16.7	1952	1920	1931	1912	No	1962	No
New York	32.1	1963	1957	1957	1921	1968	1940	No
Pennsylvania	14.3	1952	1965	1959	1913	1959	No	No
Texas	28.6	1957-1967	No	1942	1931	1927	No	No

Medical Treatment

Table III-75 presents a breakdown of cases by type of ailment treated. It can be seen that orthopedic problems account for the largest percentage (19.1%) of cases, followed by obstetric and gynecological problems which account for the bulk of the next two categories entitled genito-urinary and pregnancy related (total of 10.5%). This finding is generally in keeping with earlier studies.

Treatments

Table III-76 presents a breakdown of all cases by type of treatment rendered, which agrees with the oft reported suggestion that surgical problems are a leading cause of malpractice actions.

Alleged Negligence

Table III-77 presents a breakdown of cases by the type of negligence alleged. The first breakdown shows that failure to diagnose or improper diagnosis accounted for 10.4% of the cases, while improper treatment accounted for 89.6% Within the improper treatment category, surgical mishaps accounted for 25.0% of the cases and use of restraints or failure to supervise or control patient accounted for 11.1%.

Severity of Injury

Table III-78 presents a breakdown of cases by severity of injury. It is noted that 58% of the cases involved a permanent injury or death.

Class of Injured Party

Table III-79 shows that, so far as may be inferred from appellate cases, females bring more malpractice actions than males. This correlates with the type of treatment and is probably due almost entirely to pregnancy or obstetrics/gynecological matters. The fact that pregnancy-related treatments accounted for 6.7% of the cases should explain why there are 6.3% more females involved as plaintiffs in the reported cases than males.

Type of Action

Table III-80 summarizes the type or theory of action under which the various cases were brought. As expected, 90.4% of the cases were brought as negligence actions and 6.6% of the cases claimed wrongful death, a statutory cause

TABLE III-71.

NUMBER AND OUTCOMES OF APPELLATE CASES IN WHICH INFORMED CONSENT WAS MOST SIGNIFICANT ISSUE (SELECTED STATES)

State	Total No. Malpractice Appeals	No. of Cases (all years)	1950-1971			Pre 1950		
			No. Cases Significant	Trial % Pl	Appeal % Pl	No. Cases Significant	Trial % Pl	Appeal % Pl
California	378	12	12	0.0	25.0	0	0.0	0.0
Florida	138	3	3	0.0	0.0	0	0.0	0.0
Georgia	126	6	6	23.3	33.3	0	0.0	0.0
Illinois	105	0	0	0.0	0.0	0	0.0	0.0
Kansas	96	0	0	0.0	0.0	0	0.0	0.0
Louisiana	129	3	3	0.0	100.0	0	0.0	0.0
Michigan	129	9	3	100.0	100.0	6	0.0	0.0
Minnesota	126	3	3	0.0	0.0	0	0.0	0.0
Missouri	123	3	3	100.0	100.0	0	0.0	0.0
New Jersey	87	0	0	0.0	0.0	0	0.0	0.0
New York	327	3	3	0.0	100.0	0	0.0	0.0
Ohio	81	0	0	0.0	0.0	0	0.0	0.0
Pennsylvania	69	6	6	0.0	50.0	0	0.0	0.0
Texas	129	0	0	0.0	0.0	0	0.0	0.0
Washington	150	3	3	33.3	33.3	0	0.0	0.0
Subtotal (above states)	2,193	51	45	13.3	46.7	6	0.0	0.0
National	3,717	90	72	20.8	37.5	18	66.7	66.7

of action. Battery was alleged in 3.9% of the cases, correlating with the 3.8 percent of all cases in which consent was an issue.

Amount of Award

Amount Awarded vs. Outcome

Table III-81 arrays the breakdown of cases which were appealed after awards were made at the trial level by amount and outcome. It is immediately interesting to note that the plaintiff was successful at the trial level in 90.0% of all these cases, which means that the defendant brought 90.0% of the appeals. The defendant brought 100% of the appeals for all of the cases involving over $100,000. Conversely, the plaintiff appealed more than 12% of the cases where he was awarded a verdict of from $10,000 to $99,000 at the trial level, presumably because he believed the verdict amount was inadequate. The plaintiff was sustained on appeal more frequently in cases involving $25,000 or more than on cases involving $1,000 to $24,000. Presumably, many of these larger cases were appealed on the basis of the amount of money involved rather than because of a misapplication of legal rules or doctrines. Since award data was only available in approximately 25 percent of the appellate cases, there is a potential bias toward cases in which the amount of the award was at issue.

Amount Awarded vs. Time

Table III-82 presents data on the amount awarded in

TABLE III-72.

RESPONDEAT SUPERIOR (SELECTED STATES)

State	Total No. Malpractice Appeals	No. of Cases (all years)	1950-1971			Pre 1950		
			No. Cases Significant	Trial % Pl	Appeal % Pl	No. Cases Significant	Trial % Pl	Appeal % Pl
California	378	33	9	33.3	33.3	24	75.0	50.0
Florida	138	6	6	0.0	50.0	0	0.0	0.0
Georgia	126	9	9	66.7	33.3	0	0.0	0.0
Illinois	105	0	0	0.0	0.0	0	0.0	0.0
Kansas	96	3	3	0.0	0.0	0	0.0	0.0
Louisiana	129	12	6	100.0	100.0	6	0.0	0.0
Michigan	129	0	0	0.0	0.0	0	0.0	0.0
Minnesota	126	6	6	50.0	50.0	0	0.0	0.0
Missouri	123	15	3	0.0	0.0	12	50.0	100.0
New Jersey	87	9	3	0.0	0.0	6	100.0	0.0
New York	327	33	15	40.0	60.0	18	0.0	33.3
Ohio	81	15	3	100.0	100.0	12	100.0	50.0
Pennsylvania	69	0	0	0.0	0.0	0	0.0	0.0
Texas	129	9	3	0.0	100.0	6	100.0	0.0
Washington	150	0	0	0.0	0.0	0	0.0	0.0
Subtotal (above states)	2,193	150	66	36.4	50.0	84	57.1	50.0
National	3,717	207	87	31.0	41.8	120	65.0	50.0

765 appellate cases over time. It is significant to note that 87.8% of the smaller awards ($1,000-$5,000) stemmed from cases which took place prior to 1950. Conversely, all of the appellate cases involving awards exceeding $100,000 occurred after 1960. The average (mean) value of awards reported for all time was $22,600 vs. a mean of $77,200 in the 1966-1970 timeframe. The median, which is a more reliable measure of central tendency, is only $5,400 for all the cases and has increased from $4,000 prior to 1950 to about $32,200 between 1966-1970. All of these awards are from appeals cases, and many of these were cases in which the amount of the award is at issue, and it is likely that these averages are higher than the average award resulting from a typical trial.

Figure III-14 plots the median award value vs. time. This growth in amount of award is probably as significant a factor in the overall "malpractice problem" as the increase in number of claims. The mean value is shown in dotted lines and while the curve is substantially steeper, the average is pulled up disproportionately be a few large cases. The sample size is too small to rely on these mean values.

TABLE III-73.
NUMBER OF APPELLATE CASES AND OUTCOME BY CLASS OF DEFENDANT

	1950-1971				Pre 1950			
			Outcomes				Outcomes	
Class of Defendant	Total Number of Appeals	Per-cent of Appeals	Trial Pl Win %	Appeal Pl Win %	Total Number of Appeals	Per-cent of Appeals	Trial Pl Win %	Appeal Pl Win %
Individual:								
General Practitioner	384	28.4	19.5	39.1	540	36.1	57.8	42.2
Surgical Specialist	759	56.2	23.3	46.2	630	42.2	56.2	56.2
Non-Surgical Specialist	90	6.7	26.7	50.0	60	4.0	50.0	20.0
Dentist	75	5.6	20.0	40.0	210	14.1	51.4	57.1
Chiropractor	27	2.0	55.6	55.6	12	.8	50.0	0.0
Nurse	27	2.0	42.9	57.1	6	.4	100.0	100.0
All Other	96	7.1	33.3	28.6	36	2.4	25.0	25.0
Total	1458	108.0*	23.1	44.7	1494	100.0	54.2	48.2
Institution								
Suppliers/Mfg.	39	4.5	30.8	53.8	12	2.9	50.0	50.0
General Hospital	720	82.8	33.3	44.6	294	71.0	55.1	55.1
Psychiatric Hospital	42	4.8	64.3	28.6	18	4.3	100.0	33.3
Extended Care Facility	18	2.1	33.3	50.0	6	1.4	0.0	100.0
All Other	99	11.3	34.5	50.0	90	21.7	60.0	60.0
Total	919	105.5*	35.5	34.5	420	101.3*	56.5	55.1

* multiple responses

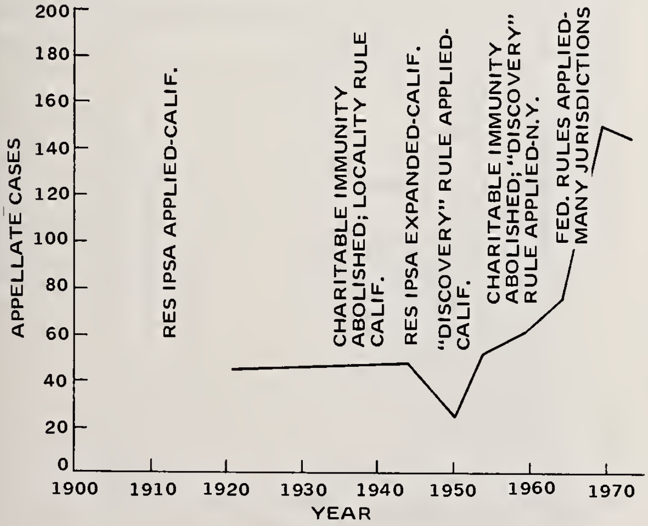


FIGURE III-11
APPELLATE CASES/YEAR–NATIONAL

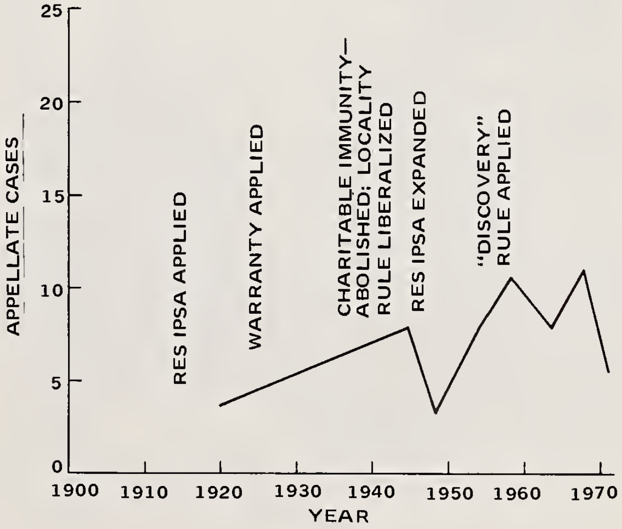


FIGURE III-12
APPELLATE CASES/YEAR–CALIFORNIA

TABLE III-74.
NUMBER OF DEFENDANTS (ALL CASES INCLUDING REPORTED TRIAL DECISIONS)

Number of Defendants	All Cases	
	No.	Percent
1	3243	77.2
2	675	16.1
3	171	4.1
4	63	1.5
5	21	.5
Greater than 5	27	.6
Total	4200	100.0

TABLE III-75.
APPELLATE CASES BY AILMENTS TREATED

AILMENT	All Cases	
	No.	Percent
Musculoskeletal System	813	19.1
Genito-urinary related	162	3.8
Pregnancy related	285	6.7
Digestive System	288	6.8
Dental Problems	279	6.5
Mental	207	4.9
Accidents, poisoning, violence	189	4.4
Respiratory System Conditions	177	4.2
Nervous System, sense organs	177	4.2
Neoplasms	144	3.4
Symptoms, ill defined	135	3.2
Circulatory System	123	2.9
Infective, parasitic	96	2.3
All other	1185	17.6
TOTAL	4260	100.0

TABLE III-76.
DISTRIBUTION OF CASES BY TYPE OF TREATMENT

Treatments	All Cases	
	No.	Percent
Unknown	714	17.5
Surgical	2340	57.3
Radiology and Nuclear	192	4.7
Pathology	15	.4
Medicine	699	17.1
Other	123	3.0
Total	4083	100.0

TABLE III-77.
DISTRIBUTION OF CASES BY TYPE OF ALLEGED NEGLIGENCE

Alleged Negligence	All Cases	
	No.	Percent
Failure to Diagnose (Total)	417	10.4
Infection, Gangrene	45	1.1
Fracture, Dislocation	90	2.2
Cancer	21	.5
Diabetes	3	.1
Pregnancy	39	1.0
Hemorrhage, Thrombosis	15	.4
Ulcer, etc.	3	.1
Appendicitis	6	.1
Tendon Laceration	3	.1
Tardiness	39	1.0
Heart	9	.2
Other	144	3.6
Improper treatment (Total)	3600	89.6
Unknown	417	10.4
Drug Related	132	3.3
Surgical	1005	25.0
Medical Equipment	336	8.4
Infection	60	1.5
During Examination, etc.	303	7.5
Fracture or Dislocation	273	6.8
Use of Restraints, etc.	444	11.1
Anesthesia Related	117	2.9
Transfusion Related	75	1.9
Injection Site	75	1.9
Abandonment	69	1.7
Casting Related	78	1.9
Legal Theory	153	3.8
Gross Misunderstanding	6	.1
Facilities	57	1.4
Total	4017	100.0

TABLE III-78.

SEVERITY OF INJURY

Severity of Injury	Significant Cases		Permanent or Death
	No.	Percent	
No Injury (Including Psychic)	123	3.5	0.0
Temp-Minor-No Delay	96	2.7	0.0
Temp-Minor-Delayed Recovery	771	21.9	0.0
Temp-Major	474	13.4	0.0
Permanent-Minor	777	22.0	22.0
Permanent-Significant	417	11.8	11.8
Permanent-Major	111	3.2	3.2
Permanent-Grave	42	1.2	1.2
Death	714	20.3	20.3
Total	3,525	100.0	58.5

TABLE III-79.

CLASS OF INJURED PARTY

Class of Injured	Cases—Multiple Response	
	No.	Percent
Male	1692	40.1
Female	1962	46.4
Minor	576	13.6
Incompetent	33	.8
Other	15	.4
TOTAL	4224	100.0

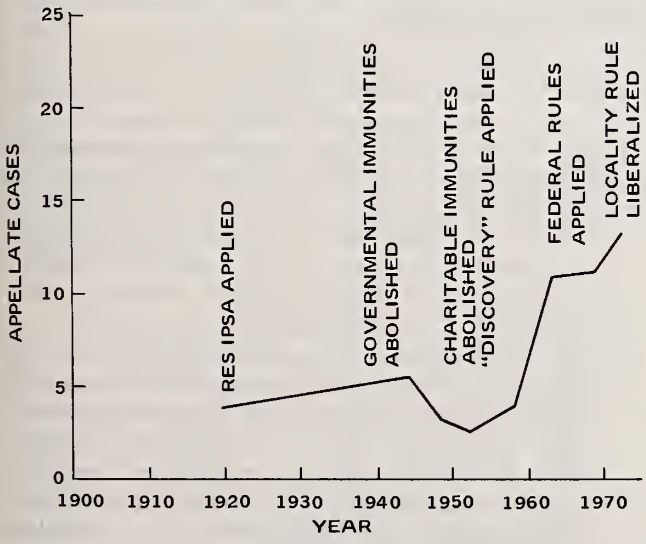


FIGURE III-13
APPELLATE CASES/YEAR—NEW YORK

TABLE III-80.

APPELLATE CASES BY TYPE OF ACTION

Type of Action	All Cases	
	No.	Percent
Contract	207	4.9
Negligence	3849	90.4
Battery	165	3.9
Deceit/Fraudulent Concealment	54	1.3
False Imprisonment	30	.7
Defamation	6	.1
Invasion of Privacy	6	.1
Interference with Family	9	.2
Breach of Confidence	12	.3
Abandonment	24	.6
Misrepresentation	6	.1
Unlawful Practice	15	.4
Wrongful Death	282	6.6
Fraud	69	1.6
Mental Distress	24	.6
Strict Liability	9	.2
Warranty	72	1.7
Other	81	1.9
Total	4260	

TABLE III-81

AMOUNT OF AWARD vs. OUTCOME

Amount of Award	Cases		Plaintiff Trial Wins	Plaintiff Appeal Wins
	No.	Percent	%	%
$1,000 to $9,000	507	65.8	92.3	53.8
$10,000 to $24,000	111	14.4	86.5	59.5
$25,000 to $49,000	66	8.6	81.8	77.3
$50,000 to $99,000	66	8.6	86.4	72.7
$100,000 to $199,000	15	1.9	100.0	80.0
$200,000 to $499,000	3	0.4	100.0	100.0
$500,000 to $999,000	0	0.0	0.0	0.0
$1,000,000 to $1,999,000	3	0.4	100.0	100.0
Total	771	100.0	90.0	58.8

TABLE III-82.

AMOUNT OF AWARD IN APPELLATE CASES vs. TIME

Amount Awarded (in thousands of $)	Pre-1950		1951-1955		1956-1960		1961-1965		1966-1970		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
$1 to 5	342	87.8	15	3.8	15	3.8	9	2.3	9	2.3	390	100.0
$6 to 10	111		9	5.7	9	5.7	18	11.3	12	7.5	159	100.0
$11 to 15	18	60.0	6	20.0					6	20.0	30	100.0
$16 to 25	6	13.3	9	20.0	9	20.0	9	20.0	12	26.7	45	100.0
$26 to 50			6	8.0			27	36.0	39	52.0	75	100.0
$51 to 75			6	28.6	3	14.3	9	42.9	3	14.3	21	100.0
$76 to 100			3	12.5	3	12.5	12	50.0	6	25.0	24	100.0
$101 to 300							3	20.0	9	60.0	15	100.0
$301 to 999							3	100.0			3	100.0
$1,000 +									3	100.0	3	100.0
Total	477	62.3	54	7.1	39	5.1	90	11.8	99	12.9	765	100.0
Mean St. Dev. Median	$4.2 $3.2 $4.0		$22.6 $24.7 $13.0		$18.8 $25.7 $ 8.0		$55.6 $90.6 $33.8		$ 77.2 $196.2 $ 32.2		$22.6 $82.5 $ 5.4	

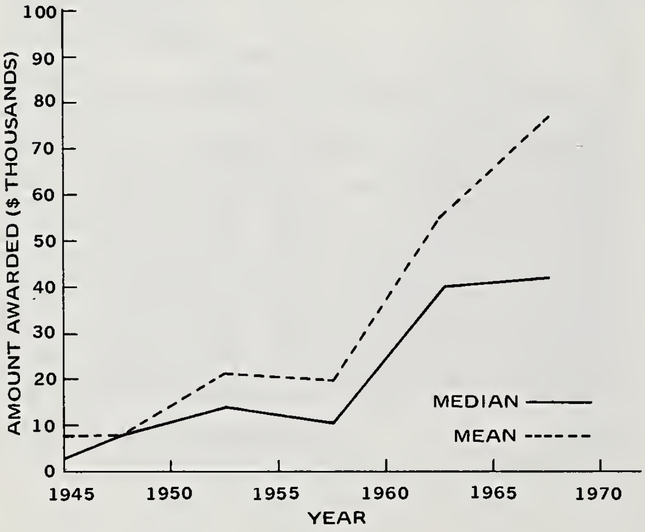


FIGURE III-14
AMOUNT AWARDED VS. TIME

IV. Major Findings and Conclusions

NOTE TO READER:

The findings and conclusions presented in this section are stated concisely without elaboration. The reader may find more extensive explanation and qualification in Section III. Many of the findings are presented separately for the National Survey and Selective Survey. The reader is reminded that:

a. only the National Survey is statistically projectable to the United States since it is based on a random sample from a national list of private practice lawyers.

b. the Selective Survey is a special population of lawyers known to members of the Secretary's Commission on Medical Malpractice for their involvement in malpractice litigation. Lawyers in the Selective Survey tend to have heavier malpractice case loads and handle larger recovery cases. However, in most other respects their case characteristics are similar to lawyers from the National Survey. Lawyers personally interviewed are a subset of the Selective Survey and represent lawyers in large metropolitan areas. Therefore, the Selective Survey results provide a group of "more experienced" malpractice lawyers for comparison with the National Survey.

MAJOR FINDINGS AND CONCLUSIONS

Volume of Malpractice Cases

a. *Per Lawyer*—Lawyers that handle medical malpractice have very few such cases per year on the average. The mean is four cases per year for defense lawyers and about one case every two years for plaintiff lawyers as a national average among lawyers with malpractice cases (i.e., not including lawyers who do not handle malpractice cases).

b. *Nationally*—Most lawyers in the National Survey had neither screened nor closed a medical malpractice case within the two-and-two-thirds year period studied. Projecting the resultant data to a national basis for the approximate 227,000 private practice attorneys exposed during the surveyed time period, we get the following picture:

1. Lawyers with no medical malpractice claims or cases	166,000
2. Lawyers with claims but no closed cases	42,000
3. Lawyers with closed cases	19,000
	227,000

Acceptance Rate

The vast majority of medical malpractice claims are rejected by the lawyers to whom they are brought. Among all lawyers who considered malpractice cases, about 12 percent of the cases were accepted.

Shopping by Claimants

Lawyers judged that 17 percent of the claims brought to them had been previously taken to another attorney. Since about four percent of the formal claims involved referral or association with another lawyer, probably no more than 13 percent of the claims represent claimants "shopping around" for a lawyer who will take their case.

Reasons for Rejection

Lawyers were allowed to choose the reasons that they reject formal claims from five alternatives. Their choices ran as follows:

Reason	National Survey	Selective Survey
No perceived liability	41%	56%
No injury suffered	6%	7%
Economic reasons	10%	23%
Statute of limitations had run	3%	4%
Other	40%	10%
	100%	100%

Case Acceptance Factors

Key criteria in the acceptance of cases reported by lawyers interviewed in the Selective Survey included medical advice or availability of medical testimony (99 percent; only three percent relied on their own opinion of medical merit), economic reasons (58 percent), apparent liability (55 percent), and client related factors (24 percent) which include client's motives and good faith.

Medical Advice

In the Selective Survey most plaintiff attorneys interviewed made use of physician friends or purchased opinions from physicians in obtaining medical advice. The majority of plaintiffs' attorneys indicated that availability of medical advice by which the merits of their clients' claim could be fairly evaluated was the most significant impediment to the speedy resolution of a dispute.

Estimate of Frequency of Malpractice

Both plaintiff and defense attorneys interviewed in the Selective Survey estimate that there is a true case of medical malpractice in one third of all malpractice claims brought before them.

Time to Handle Cases

Both plaintiff and defense attorneys in the Selective Survey of known malpractice lawyers, overwhelmingly agreed that medical malpractice cases take more time than do other personal injury cases. The increased time factor was estimated at approximately four times that of other personal injury cases.

Case Delays

Based on closed cases, lawyers estimated that mean docket delay runs 15 months (National Survey) to 21 months (Selective Survey), while case duration runs 19 months (National Survey) to 28 months (Selective Survey).

Case Disposition

The final disposition of recently closed cases shows that about two-thirds of the cases are settled. The distribution of outcome is as follows:

Disposition	National Survey	Selective Survey
Settled	66%	64%
Tried	17%	29%
Abandoned	11%	5%
Other	6%	2%
	100%	100%

Point of Settlement

Most cases are settled just before the trial. The overall distribution of point of settlement is given below:

State of Proceedings	National Survey	Selective Survey
Before suit filed	24%	5%
Before trial	68%	70%
During trial	8%	18%
After trial	0%	7%
	100%	100%

Impediments to Settlement

In the personal interviews of the Selective Survey, about half of the plaintiff lawyers cited the "defendants' right to refuse settlement" as a major impediment to pretrial settlement of medical malpractice cases. About one-third of these lawyers mentioned insurance company "last ditch" defense efforts.

Appeals

The portion of tried cases appealed were reported in the National Survey to be 29 percent and 23 percent in the Selective Survey.

Win Rates

The National Survey indicated plaintiff recovery rates of 68 percent while the Selective Survey showed recovery rates of 79 percent. These percentages included all settled cases as a "plaintiff win," even if the defendant was happy with the settlement amount. If we look at only tried cases, this effect is eliminated and the plaintiff win rate reduces to 44 percent (National Survey) and 63 percent (Selective Survey). The severity of the injury and the defendant type had little effect on win rates.

Recovery Amounts

Mean gross recovery for cases in the National Survey was $22,000. For cases in the Selective Survey it was $81,000. Mean recovery to the client, including recovery for medical expenses, was $7,200 in the National Survey and $35,700 in the Selective Survey. Mean legal fees were $5,800 in the National Survey and $20,000 in the Selective Survey.

The median recovery amount (amount exceeded half the time) is well below the mean. Median gross recovery was $3,500 in the National Survey and $25,000 in the Selective Survey. Even if attention is focused on only those cases with non-zero recovery, the median gross recovery is only $13,000 and $35,000, respectively, for the two surveys.

Legal Combines

Familiarity—Seventy-one percent of those in the National Survey and 64 percent of the Selective Survey had never heard of legal combines. Another nine percent and six percent, respectively, although they had heard of them, could not describe how they operated. There was practically no evidence of participation in them.

Influence of Contingent Fee on Case Acceptance

The contingent fee arrangement does not encourage lawyers to accept nonmeritorious cases with a low probability of winning just because the possible recovery is large.

The contingent fee arrangement can be expected to discourage a lawyer from accepting a meritorious claim if the expected recovery is low because small cases still require some minimum number of lawyer hours. Note, however, that this is not solely a property of the contingent fee system. Even with an hourly fee arrangement the plaintiff would likewise be discouraged from engaging a lawyer when expected recovery is low.

Reasonableness of Fees Earned Under Contingent Fee Arrangement

There does not appear to be any gross discrepancy between the effective hourly fee earned by plaintiff lawyers under the contingent fee arrangement and the normal hourly fee charged by defense attorneys in medical malpractice cases on the average.

Uncompensated Lawyer Hours Under Contingent Fee Arrangement

The contingent fee arrangement leaves plaintiff lawyers with no payment for their legal services when cases are lost. Our study revealed that such cases are not minor efforts but an average (mean) of over 400 attorney hours were spent per uncompensated case.

Lawyers Opinions on Impact of Contingent Fee Arrangement on Claimants

Attorneys interviewed in the Selective Survey commonly believe that the contingent fee arrangement provides legal counsel to clients who have meritorious claims but could otherwise not afford legal representation. This is further supported by the fact that legal and other costs absorbed by the lawyer under the contingent fee are more than the average American could be expected to finance on his own.

Typical Contingent Fee Percentage

Virtually all plaintiff attorneys use a contingent fee arrangement in medical malpractice cases (with fee as a fixed or sliding percent of recovery). The most common fixed contingent fee is 33-1/3 percent of the recovery amount.

Influence of Legal Doctrines

The study confirmed that changes over the past two decades of certain key legal doctrines have a definite bearing on the outcome of a malpractice action in appellate cases.

Res Ipsa Loquitur

The application of *res ipsa loquitur* in appellate cases has been relatively infrequent, except in California, where it is applied more liberally. In the past 10 years, California accounted for over 60% of all appellate cases involving *res ipsa loquitur.* When *res ipsa* is applied to the facts, the plaintiff generally wins on appeal more frequently than the average for all appellate cases.

Discovery Rule

The recent application of the "discovery rule" to statute of limitations issues in the majority of states has resulted in a high percentage of plaintiff wins at the appellate level for these cases. This signifies that appellate courts do attempt to ameliorate otherwise harsh (albeit legally valid) rules in certain fact situatioons.

Locality Rule

The relatively recent expansion of the locality rule to include "similar localities or communities" has made it easier for the plaintiff to produce expert testimony in many jurisdictions.

Influence of Doctrine on Number of Cases

Although it is not possible to demonstrate a cause-and-effect relationship between the number of appeals and the volume of trial cases, it can be shown that the availability of certain key doctrines has influenced the number of appeals in a given jurisdiction.

California Landmark Case

In California, there was a marked increase in the rate of malpractice appeals a few years after the landmark case of Ybarra vs. Spangard in 1944, which expanded the application of *res ipsa (Ybarra vs. Spangard,* 25 Cal. 2d 486, 154 P. 2d 687, 1944).

Liberalized Rules and Doctrines

A combination of liberalized rules and doctrines put into effect in the mid-fifties in New York other and states was accompanied by a rise in the rate started in the late fifties or early sixties.

Appeals by Plaintiff Versus Defendant

There has been a marked trend toward the plaintiffs' bringing the majority (75%) of the appeals since 1950 as compared with about 50% prior to 1950. This means that, for the reported appellate cases in recent years, the plaintiff lost at the trial level in nearly 75% of the cases. If the plaintiffs are winning a greater percentage of all trial cases, as commonly alleged, then the defendants are not appealing the same proportion of cases as they did prior to 1950. It would seem that, with a trend toward larger verdicts, the defendants would have more incentive to appeal the cases they lost at a trial level.

Average Award in Appealed Cases

The average award in appealed cases grew from $22,600 in the 1951-1955 period to $77,200 in the 1966-1970 period.

Multiple Defendants in Appealed Cases

There is more of a tendency to involve multiple defendants in states that have liberalized the application of *res ipsa.* While 77% of all cases analyzed involved only one defendant, only 39% of the cases in California involved a single defendant.

V. Recommendations for Further Research

At the conclusion of this research study there are a number of additional areas of investigation which could yield greater insight into the medical malpractice problem through further research. These topics have been identified briefly below.

Co-Counsel Fee

A more accurate measure of co-counsel fees is needed (both frequency of occurrence, and percentages). This information was unfortunately not collected on a case-by-case basis in the Legal System Study just completed and an overall estimate was used.

Effective Fee Distribution

With the information provided above it would be possible to calculate "effective hourly fee" on individual cases for plaintiff lawyers working under contingent fee arrangements after the co-counsel fee was removed. It would then be possible to examine the cumulative distribution of "net effective fee" earned by the plaintiff attorney. An examination of this distribution (as opposed to just the mean effective fee) would provide a better understanding of the frequency with which and conditions under which attorneys who use the contingent fee arrangement are seriously under-compensated, fairly compensated and over-compensated. This, in turn, could provide guidance for the development of state wide standard contingent fee rates which a few states (New Jersey, New York) already adopted.

Shopping Around for a Lawyer

Information obtained from lawyers on their impressions of the number of claims previously taken to another lawyer are only approximate. This question should obtain a more accurate response if asked of a sample of claimants (and perhaps non-claimants with recent hospital or medical maloccurrences).

Meritoriousness of Cases

In this study lawyers in the personal interviews (non-random, nonprojectiable sample) were asked in what fraction of cases they felt there was malpractice. More detailed inquiry in this area would be useful. Specifically the different aspects of meritoriousness should be asked (e.g. was there injury? negligence?, etc.) as well as degree of certainty (e.g. obviously present, probably present, unlikely, definitely not present).

Comparison with Other Personal Injury Suits

A comparison of medical malpractice case results with other personal injury suits would provide a useful base of comparison for evaluating amounts of recovery, for comparable injury case duration and other characteristics of malpractice cases.

Point of Settlement

Our research results show that about 2/3 of all cases are settled after the suit is filed but before trial. Further research could show exactly where this settlement occurs especially in terms of nearness to the trial date.

Impediments to Settlement

Plaintiff lawyers raised serious questions concerning insurance companies' willingness to settle cases before the trial. A larger study of defense attorneys could shed more light on this problem, and could identify circumstances under which this occurs and possible changes that could be made.

Methodology

Several suggestions on methodology have resulted from the survey of lawyers which may be useful in further studies of this type.

a. The mail survey approach was quite successful and lawyer cooperation was encouraging. A two phase mailing would allow initial screening of lawyers who "ever had" or "recently had" screened or closed a medical malpractice case and determine plaintiff or defense affiliation. The second phase could then direct the appropriate questions to the proper subpopulation groups.
b. A subsample of lawyers could be selected for verification of reported statistics against law office records (where records exists). This would help to answer questions about the accuracy of "recalled" facts reported by lawyers. Alternatively a subsample could be asked to express their own degree of uncertainty on reported items (e.g. the case duration was estimated as 24 months ± 4 months).

Survey of Physicians

A number of questions arising in this study would benefit from a response from the physicians' point of view. Success in obtaining lawyer cooperation and previous experience in surveying doctors leads us to believe that further research of this sector of the malpractice issue is feasible as well as useful Specific issues which physicians would be asked about include:

a. *expert witness.* Under what circumstances would doctors be willing or refuse to give testimony as an expert witness in a medical malpractice case.
b. *self regulation.* What do doctors think of the success of medical societies in policing their members.
c. *meritoriousness of claims.* With regard to claims against (1) themselves and (2) other physicians, hospitals, etc., how do doctors characterize claims? usually reasonable and accurate?, exaggerated?, unfounded?, etc.
d. *motives of claimants.* What do doctors think the most common motives of the claimant are: recovery of money due to injury? anger against doctor? misunderstanding about expected outcome?, etc.
e. *patient-doctor relationship.* How do doctors characterize recent trends in patient-doctor relationship? What has influenced this relationship? What might be done to improve it?
f. *non-physician role.* What do doctor's see as the contribution of deficiencies or limitations in the hospital, medical technicians and support staff, drugs, equipment and facilities to incidences of maloccurrences that may lead to malpractice claims?
g. *human error.* How frequently do doctors (of various specialties) believe that human error or an honest mistake leads to maloccurrences or malpractice claims?
h. *doctor's reluctance to settle.* What factors do doctors consider important in deciding whether or not to settle? (e.g. impact on their carrier, reputation, insurance rate, fairness and justice, etc.)
i. *influence on medical practice.* How does the threat of possible malpractice suits influence the doctors' practice of medicine (e.g. more tests called for? reluctance to work on high liability patients or under high risk conditions?)
j. *insurance rates.* What recent changes have doctors experienced in their medical malpractice insurance?

Legal Doctrines and Appellate Cases

A number of additional questions, proposed studies and analyses have been suggested as a result of delving into the examination of legal doctrines applied to malpractice. The most significant of these are outlined below. Many of these involve further analysis of the existing data base of appellate and reported trial cases.

a. *determine if California is setting standards for Malpractice Law.* This task would involve a reexamination of the sampled cases to identify any California citations, which are cited as authority in other states.
b. *determine hypothetical outcomes under assumed uniform laws.* An interesting task would involve a reexamination of all or a sample of the opinions in the data base to determine what the outcome would have been if all of the liberalized doctrines has been available to the court in the particular jurisdiction.
c. *analyze reported trial decisions.* The data base includes approximately 170 trial cases from New York, Federal district courts, and a few California reported trial opinions. It would be useful to analyze this set of decisions in the same manner as were the appellate cases and determine what differences exist in the two files. It should be noted that the reported trial cases are not a good surrogate for all

trial cases, since an opinion is generally not written if the case goes to the jury and a verdict is reached.

d. *analysis of actual trial records.* It would be useful to conduct an analysis of trial records using a projectable sampling approach. This would serve to confirm or deny whether the reported outcome at trial level of all cases on appeal bears any relationship to the outcome of all cases at the trial level. This study would be most reliably conducted by sampling actual court records in several jurisdictions. An alternative approach would be to examine a sample of litigation files from a number of defendant insurance companies and their attorneys.

e. *correlate malpractice appeal results to all personal injury appeals.* One approach to determining whether the growth in malpractice appeals, and the outcomes thereof, is significant would be to compare these statistics with a sample of selected appellate decisions. The key parameters would involve.

(1)total number of personal injury appellate cases by year,

(2)outcomes of personal injury appellate cases by year,

(3)similar results for selected states.

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Appendix A

Lawyer Survey Questionnaire

The questionnaire, shown in this appendix, is divided into three parts. Part I, the General Information Form, requests information about the respondent lawyer's practice, his screening of potential clients, fee arrangements and factors influencing acceptance and rejection of cases. Part II contains Individual Case Information Forms which were used to secure specific information on up to five of the respondent's most recent cases closed after January 1, 1970. Since the five Case Information Forms are identical, only one is presented in this appendix. Part III, the Personal Interview Data Form, is a more in-depth examination of points covered in Parts I and II as well as the respondent lawyer's opinions and observations about handling malpractice cases. Parts I and II were used in the mail survey, and Parts I, II, and III in the personal interviews.

GENERAL INFORMATION AND INSTRUCTIONS

This questionnaire is divided into two parts:

Part I — General Information Form
Part II — Individual Case Information Forms

IMPORTANT: Questions in both parts refer to medical malpractice claims initiated or cases terminated since *January 1, 1970.* These questions refer to your own, personal practice of law. Your answers should *not* reflect experiences of your colleagues.

A. If *no* claims of alleged malpractice have been brought to your attention by potential clients since January 1, 1970, check this box and return this questionnaire in the envelope which is provided. .... ☐1

B. If one or more claims of alleged malpractice were brought to you but you did *not* represent the client — check this box, and complete *only* questions 1 through 5 of the General Information Form. .... ☐2

C. If you have accepted one or more malpractice cases for *personal handling* (i.e., acted as the lawyer responsible or the lawyer most familiar with the case), check this box and complete everything in Part I and Part II. .... ☐3

O.M.B. No. 085-S72017
Approval expires Nov. 30, 1972

PART I: GENERAL INFORMATION FORM

1. Including yourself, how many attorneys practice law in your law office, partnership, or professional corporation? ______ attorneys 3

2. Of this total number, how many have handled one or more medical malpractice cases since January 1, 1970? ______ attorneys 4

3. Since January 1, 1970, how many claims of alleged malpractice were —

Number of Claims

A. brought to your attention for formal consideration (for instance visit or telephone call to your office)? . . . . ______ 5

B. mentioned to you informally (for instance, at social gatherings)? . . . . ______ 6

4. Of the total claims in 3-A plus 3-B, how many, do you estimate, had been previously taken to another lawyer? . . . . ______ 7

5. Of those claims brought to your attention for formal consideration (cited in Question 3-A), please indicate:

Number of Claims

A. Total number of claims you rejected . . . . ______ 8

B. What was your major reason for rejecting each of these claims? (Specify number of potential cases you rejected primarily for each reason)

- no perceived liability . . . . ______ 9
- potential client suffered no damage . . . . ______ 10
- "economic reasons" such as damage too small . . . . ______ 11
- running of statute of limitation or other legal bars to recovery . . . . ______ 12
- other reasons (please specify): ______ 13

______

6. Of those claims of alleged malpractice brought to your attention for formal consideration (cited in Question 3-A), how many did you —

Number of Claims

A. refer to other counsel? . . . . ______ 14

B. associate other counsel for assistance? . . . . ______ 15

C. accept for personal handling? (i.e., act as the lawyer responsible or the lawyer most familiar with the case). . . . . ______ 16

7. What is your normal fee arrangement on medical malpractice cases? (Fill in only one of A, B, C, or D.)

A. Hourly Fee at hourly rate of . . . . $______ 17

B. Fixed Contingent Fee with percentage of recovery at . . . . ______% 18

C. Contingent Fee with sliding percent — describe: ______ 19

______

______

D. Other Arrangement—describe: ______ 20

______

8. What is the average docket delay in your jurisdiction for civil cases (i.e., time from filing to trial)? ______ months 21

9. Please identify any statutes, rules of substantive law, procedure, evidence, or other factors which you believe have the greatest bearing on your —

A. acceptance of cases. ______ 22

______

______

B. processing of cases. ______ 23

______

______

10. There have been some cases, for example the Thalidomide drug cases, where groups of plaintiffs' attorneys have combined forces to seek redress for a common grievance. Are you familiar with any such legal combines and how such groups are formed and function? Please Describe:

______ 24

______

______

PART II: INDIVIDUAL CASE INFORMATION FORMS

______________ 1

1. Jurisdiction of this case

City or County ______________ 2

State ______________ 3

2. Did you represent:

☐1 Plaintiff? 4

☐2 Defendant?

3. Defendant Types

examples: plastic surgeon
pediatrician
aides
hospital

Type

Defendant #1 ______________ 5

Defendant #2 ______________ 6

Defendant #3 ______________ 7

All Others ______________ 8

4. Characteristics of Injured Person

- Age: ______________ years 9
- Sex: ☐1 Male ☐2 Female 10
- Marital Status: ☐1 Single ☐2 Married ☐3 Widowed ☐4 Divorced ☐5 Unknown 11

5. Medical Injury

example: A. appendicitis
B. appendectomy
C. transfusion—wrong type
D. renal failure

A. Diagnosis ______________ 12

B. Treatment ______________ 13

C. Alleged Malpractice ______________ 14

D. Injury Alleged ______________ 15

6. Case Duration (from case acceptance to date of fixing sum certain, even if zero—best estimate)

A. Duration ______________ months. 16

B. Year case closed: 19______________. 17

7. Lawyer hours on this case (total hours by you and your firm—best estimate) ______________ hours. 18

8. Final Disposition (after all appeals, if any)

Defendant #1 19	Defendant #2 20	Defendant #3 21
☐1 Settled	☐1 Settled	☐1 Settled
☐2 Tried	☐2 Tried	☐2 Tried
☐3 Abandoned	☐3 Abandoned	☐3 Abandoned
☐4 Other	☐4 Other	☐4 Other

9. If SETTLED, when?

Defendant #1 22	Defendant #2 23	Defendant #3 24
☐1 Before suit filed	☐1 Before suit filed	☐1 Before suit filed
☐2 Before trial	☐2 Before trial	☐2 Before trial
☐3 After trial (for amount different than judgment)	☐3 After trial (for amount different than judgment)	☐3 After trial (for amount different than judgment
☐4 Other	☐4 Other	☐4 Other
☐5 Not settled	☐5 Not settled	☐5 Not settled

10. If TRIED:

	Defendant #1	Defendant #2	Defendant #3
A. Was case ever appealed?	☐1 Yes ☐2 No 25	☐1 Yes ☐2 No 26	☐1 Yes ☐2 No 27
B. Final outcome, after all appeals and trials, in favor of:	☐1 Plaintiff ☐2 Defendant 28	☐1 Plaintiff ☐2 Defendant 29	☐1 Plaintiff ☐2 Defendant 30

11. Fee Arrangement

1. Contingent ______________% 31
2. Hourly fee $______________ 32
3. Other (Specify) ______________

12. Recovery

Gross Recovery . . . . $______________ 33

- Case expenses charged your client . . . . $______________ 34
- Fee charged your client . . . . $______________ 35
- Other . . . . $______________ 36
- Medical bills . . . . $______________ 37
- Net to client . . . . $______________ 38

Part III. Personal Interview Data Form

1. *Screening criteria*
   - A. How do you decide to accept a malpractice case?
   - B. Percent of claims where malpractice is clear . . . %
   - C. Do malpractice claims require more time? . . . . . .

2. *Medical Advice and Expert Witness*
   - A. How do you get medical advice?
   - B. Locality rule—adhered to in this jurisdiction? What is its effect on obtaining expert witness?

3. *Case Referral*
   - A. Why do you refer cases?
   - B. Referral fee arrangement. What is your customary percent? . . . .

4. *Contingent Fee*
   - A. How does the contingent fee arrangement influence incidence and disposition of claims?
   - B. How do you feel about Court or jury determining your fee?

5. *Settlement*
   - A. How do you decide what amount to seek for award or settlement?
   - B. Major impediments to pre-trial settlement in this jurisdiction:
   - C. Do insurance companies refuse to negotiate prior to suit? . . . .

     Increase in amount sought when this happens . . . .

6. *Judge*
   - A. Do judges encourage pre-trial settlement? . . . .
   - B. Do judges influence outcome? How often? What method?

7. *Trial Tactics*
   - A. Factors in selecting jury:
   - B. Factors that influence jury in malpractice case:
   - C. Strengths and weaknesses of jury verdicts:

8. *Jury Understanding*
   - A. Does jury usually understand medical issues? . . . . .
   - B. Does jury usually understand court instructions on law? . . . .

Appendix B

Case Characteristics From Lawyer Survey

This appendix presents the characteristics of cases reported in the National Survey and the Selective Survey. Included are the geographical distribution of the cases, characteristics of injured persons (age, sex, marital status), medical characteristics (type and severity of injury, alleged malpractice), and types of defendants.

1. GEOGRAPHICAL DISTRIBUTION

Thirty-six attorneys in the National Survey reported 71 cases distributed over 23 states across the United States. In the Selective Survey, 154 attorneys reported 485 cases in 31 states. The number of reported cases in each state is shown below in Table B-1.

TABLE B-1.

NUMBER OF CASES REPORTED BY STATE

National Survey	Number of Cases in Each
Massachusetts, Michigan, Mississippi, North Carolina, South Carolina, South Dakota, Wisconsin	1
Florida, Hawaii, Maryland, Montana, Ohio, Tennessee, Virginia, Texas	2
Arkansas, Georgia, Washington	3
Arizona	5
Kansas	6
California	7
Illinois	8
Missouri	13
Not reported	2
Selective Survey	
Alabama, Arkansas, Delaware, Kansas, Louisiana, Minnesota, Nebraska, Utah, West Virginia	1 - 3
District of Columbia, Iowa, Missouri, Nevada, New Mexico, Ohio, Tennessee	4 - 6
Arizona, Indiana, Maryland, Oregon, Texas, Virginia	7 - 10
Florida, Massachusetts, Michigan, New Jersey, New York, Pennsylvania, Washington	11 - 25
California, Illinois	26 and over
Not reported	12

2. CHARACTERISTICS OF INJURED PERSONS

Age

In both surveys, the cases revealed that most injured persons were in the 21-39 and 40-59 age groups.

TABLE B-2.

INJURED PERSON BY AGE

	National Survey*	Selective Survey**
Under 21	19%	21%
21 - 39	38%	35%
40 - 59	33%	36%
60 and over	10%	8%
	100%	100%

*Based on 69 cases in which age was reported.
**Based on 471 cases in which age was reported.

TABLE B-3.

INJURED PERSON BY SEX

	National Survey*	Selective Survey**
Male	55%	47%
Female	45%	53%
	100%	100%

*Based on 69 cases in which sex was reported.
**Based on 478 cases in which sex was reported.

Sex

From the cases reported in the National and Selective Surveys, it was found that injured persons were rather evenly divided between male and female.

Marital Status of Injured Person

Table B-4 below shows that by far most of the injured persons in the cases from both surveys were married. It should be noted that when there was no indication of marital status minors and infants were coded as "single".

3. TYPE OF DEFENDANT

From the cases reported in the National Survey one sees that physicians are the most frequently reported type of defendant (35 percent), followed closely by surgeons (31 percent) and hospitals (23 percent). The Selective Survey, however, shows surgeons first (38 percent) with physicians next (23 percent) and hospitals third (24 percent). Shown below in Table B-5 are the percentages of each type of defendant reported in both the National and Selective Surveys. Percentages are based on 96 reported defendants in the National Survey and 946 in the Selective Survey.

TABLE B-4.

MARITAL STATUS OF INJURED PERSON

Status	National Survey* Percent in Group	Selective Survey** Percent in Group
Single	21	27
Married	65	65
Widowed	3	3
Divorced	11	4
Unknown	0	1
	100%	100%

*Based on 66 cases in which marital status was reported.
**Based on 463 cases in which marital status was reported.

TABLE B-5.

TYPE AND PERCENT OF DEFENDANTS

Defendant Type	National Survey	Selective Survey
Physician	35%	23%
Surgeon	31%	38%
Hospital	23%	24%
Osteopath	2%	2%
Medical Services*	0	.5%
Medical Suppliers**	0	.5%
Manufacturers***	1%	3%
Employee†	1%	4%
Other††	7%	5%
	100%	100 %

*Physical therapists, ambulance company, etc.
**Pharmacy, diothermy machine, etc.
***Drug company, heart pacemakers, etc.
†Nurse, technician, orderly, etc.
††Optician, podiatrist, dentist, etc.

4. MEDICAL CHARACTERISTICS

Injury

The injury alleged in each case was classified twice using first a three-digit code and then using a one-digit severity code.[1] The three-digit code measured three dimensions separately: (a) severity of injury, (b) delay in recovery, and (c) completeness of recovery. The one-digit code combined and measured the same three factors (severity, delay in recovery, amount of recovery) on a one to nine scale which is explained in Figure B-1. The results from both surveys are shown below.

---

[1] See "Medical Malpractice Insurance Claims Files Closed in 1970," *Supra,* pp. 1 ff.

FIGURE B-1.
SEVERITY SCALE

Severity Scale	Amount or Recovery	Severity of Injury	Delay in Recovery	Examples
1	No Injury	Insignificant	N/A	Psychological, fright, catheter inserted, dissatisfaction (doctor too slow), unauthorized autopsy
2	Temporary Injury	Minor	No Delay	Lacerations, bruises, contusions, minor scars, rash, broken caps of teeth, minor allergic reaction
3	Temporary Injury	Minor	Delayed	Operation-induced infection, misset fracture, failure to diagnose glass in cut, staph infection from lack of antibiotics, broken ankle from fall
4	Temporary Injury	Major	Delayed	Burns, surgical material left, drug side-effect, severed nerve or tendon
5	Permanent Injury	Minor	N/A	Loss of fingers or toes, foot drop, withered arm, loss of teeth, dysfunction of ankle
6	Permanent Injury	Significant	N/A	Deafness, loss of limb, loss of eye, loss of one kidney or lung, gross deformity of limb
7	Permanent Injury	Major	N/A	Paraplegia, blindness, loss of two limbs, brain damage, etc.
8	Permanent Injury	Grave	N/A	Quadraplegia, severe brain damage, comatose, lifelong care, etc.
9	DEATH	N/A	N/A	N/A
0	Unknown			

Alleged Malpractice

The alleged malpractice reported in each case in both the National Survey and the Selective Survey was reviewed and placed in a subcategory under one of two major categories, "Failure to Diagnose" or "Improper Treatment" and then further classified. The results of both surveys are shown in the tables below. It should be noted that most instances of alleged malpractice in both surveys were due to improper treatment (79 percent in National and 78 percent in Selective Survey).

TABLE B-6.
INJURY ALLEGED

	Percent Cases National Survey	Percent Cases Selective Survey
Severity		
None	2	2
Minor*	47	48
Major**	25	23
Death	26	27
Total	100% (53 cases)	100% (116 cases)
Delay in Recovery		
None	6	5
Minor (less than one month)	3	4
Major (more than one month)	91	91
Total	100% (32 cases)	100% (250 cases)

Amount of Recovery		
Complete (temporary injury)	31	28
Incomplete (aided)***	45	40
Incomplete (unaided)†	24	32
Total	100% (38 cases)	100% (290 cases)

*Something was damaged but not removed, e.g., surgical scar, or broken ankle.

**Amputated member or something removed from body or complete loss of sense organ, e.g., blindness.

***Permanent injury with reasonable prosthetic device available, or possible permanent injury.

†Permanent injury with no prosthetic device available.

TABLE B-7.

SEVERITY OF INJURY ALLEGED

Severity	Percent Cases National Survey	Percent Cases Selective Survey
0 (Unknown)	14	9
1	8	1
2	10	2
3	8	6
4	11	16
5	14	21
6	15	10
7	1	6
8	0	6
9 (Death)	19	23
Total	100% (73 cases)	100% (494 cases)

TABLE B-8.

ALLEGED MALPRACTICE

	National Survey*	Selective Survey**
Failure to Diagnose		
Infection, gangrene	2%	3 %
Fracture, dislocation	5%	4 %
Cancer	3%	4 %
Diabetes		
Pregnancy and related	2%	2 %
Hemorrhage or thrombosis	2%	1 %
Ulcer	2%	1 %
Appendicitis		.4%
Tendon laceration	2%	.6%
Due to tardiness or lack of attention	2%	.5%
Heart and associated disorders	3%	.5%
Total	21%	22 %
Improper Treatment		
Unknown	6%	3 %
Drug related	5%	11 %
Surgical material left	29%	25 %
Medical equipment	17%	9 %
Infection	2%	2 %
During examination		
Insufficient therapy, error in prescription	3%	6 %
Fracture or dislocation		.5%
Use of restraints, improper supervision, control	3%	4 %
Anesthesia related	2%	6 %
Transfusion related		2 %
Injection site injuries	2%	2 %
Abandonment	2%	.5%
Casting-related problems	2%	2 %
Legal theory	8%	5 %
Gross patient misunderstanding		
Total	79%	78 %

*Base on 63 reported cases.

**Based on 460 reported cases.

Appendix C

An Analysis of the Accuracy of Statistical Sampling in Estimating Reported Appellate Decisions

This appendix compares the projected number of medical malpractice appellate decisions derived through statistical sampling in this study, with two similar studies published in 1957. It is concluded that a remarkable degree of consistency in the estimated numbers of total medical malpractice appellate decisions was obtained through the statistical sampling approach.

The data base used in this study was accumulated by Aspen Systems Corporation through a comprehensive search of the American Law Reports (ALR) and the table of cited cases contained in Louisell and William' treatise, *Medical Malpractice.*[2]

Two earlier studies, one by Sandor, and a study published in the same year prepared by the Law Department of the American Medical Association, were used as the basis of comparison.[3, 4]

Sandor's monumental work analyzed all appellate decisions from the period 1794 through 1955 which were reported in the United States. The AMA study analyzed medical professional liability decisions reported from 1935 through 1955.

Sandor meticulously limited his analysis to only appeal cases, both courts of intermediate appellate jurisdiction and last instance. The AMA study included "all published decisions . . . no matter what the level of the court involved." It was indicated, however, that the AMA study consisted primarily of the decisions of the highest court of the state as well as intermediate appellate courts. Reported decisions of trial courts are published in only a few jurisdictions and were used in the AMA study only "in a few instances." Statistics are not reported in the AMA study showing a breakdown of intermediate appellate and highest courts' percentages for all states. The AMA study identified, in addition to the state and District of Columbia reported decisions, 19 "federal" decisions. Sandor properly included federal decisions based on diversity of citizenship in the state in which the trial was held, but does not indicate whether any of the reported cases included those arising under the laws of the United States within the exclusive purview of federal jurisdiction.

To reconcile the comparison between the results of these three studies, the timeframe was delimited by that of the AMA study—from 1935 through 1955. Fortunately, comparable time frames were easily extracted from both Sandor's study and the statistical projections of reported appellate decisions used in this study.

All of the studies included some limitation on their selection of a case for study. The most difficult restriction against which comparability was measured was the class of case based on allowable party defendant. This present study allowed in its coding rules 13 major categories of individual defendants subcategorized into 26 specialty areas of practice. The major categories are listed in Table C-1. In addition, this current study identified and included six major categories of institutional defendants with 16 subcategories also shown in the table. Sandor was most meticulous in limiting his analysis to only physicians and within that category only to doctors of medicine.[5]

The AMA study is not specific in its analysis of "medical professional liability decisions" to indicate the exact scope of who was included as defendants, but the degree of comparison between its work and that of Sandor indicates a reasonable degree of similarity, suggesting strongly that it, too, was limited to doctors of medicine.

Statistics for those years which could be compared in these three studies and their degree of comparability are shown in Table C-2. Noted in the table are the comparative estimates derived by Aspen Systems Corporation for California and the United States and the same estimates for the two earlier studies. California was selected as the state for comparison since all three studies agree that it has the highest number of reported decisions when the reported cases of the highest court and the intermediate appellate courts are added. In the table, adjustment factors for the pre-1950 and post-1950 time periods were applied to the Aspen Systems Corporation projected totals. These adjustment factors of 0.642 and 0.518 were obtained by deriving the proportion of cases from Aspen's data base which, for the two timeframes, represented the proportion of physicians and surgeons included as defendants in the reported cases. This proportion, when applied to the total, results in the total adjusted proportions for the highest state court and intermediate appellate courts shown in the table. The total highest and intermediate court reported decisions shown in the table are the sum of the adjusted proportions for the Aspen Systems data, and the numbers reported by Sandor and the AMA.

The final line of the table indicates the ratio of Aspen Systems' projections to the previously published studies of Sandor and the AMA. It can be concluded from the ratio shown in the table that the Aspen Systems sampled projections are within two and one-half percent to about nine percent of the Sandor and AMA studies, reporting a slightly higher fraction than both studies for California

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[2] Louisell, D., and Williams, H., *Medical Malpractice,* New York, Matthew Bender & Co., Inc. (1972 supp.).

[3] 163 J.A.M.A. 459, Sandor, A., "The History of Professional Liability Suits in the United States," Feb. 9, 1957.

[4] 164 J.A.M.A. 1349, "Court Decisions—Medical Professional Liability," July 20, 1957.

[5] "Eliminated from the survey are actions against osteopaths, chiropractors, dentists, veterinarians, nurses, druggists, medical and X-ray technicians, Christian Science healers, botanic physicians, chiropodists, midwives, naturopaths, sanipractors, magnetic healers, masseurs, optometrists, hospitals, and sanitoriums." *Sandor,* at 460-464. Also eliminated from Sandor's study were actions against "employers of physicians who are sued for negligent acts of the physician-employee on the theory of agency, criminal malpractice, and proceedings of state licensing boards;" and all cases in which a physician sues a patient for fees and "the patient then cross-files (sic), alleging malpractice as a defense." *Sandor,* at 464.

TABLE C-1
CLASS OF DEFENDANT

CLASS OF DEFENDANT

INDIVIDUAL

- General Practitioner

- Surgical Specialist
  - Anesthesiologist
  - General Surgeon
  - Neurological Surgeon
  - Obstetrician/Gynecologist
  - Opthalmologist
  - Orthopedist
  - Otolaryngologist
  - Plastic Surgeon
  - Proctologist
  - Thoracic Surgeon
  - Urologist

- Non Surgical Specialist
  - Dermatologist
  - Internist
  - Neurologist
  - Pathologist
  - Pediatrician
  - Physical Medicine and Rehabilitation
  - Preventative Medicine
  - Psychiatrist
  - Radiologist

- Dentist
  - General Practitioner
  - Oral Surgeon
  - Periodontist
  - Orthodontist
  - Endodontist
  - Other

- Chiropractor

- Podiatrist/Chiropodist

- Optometrist

- Registered Nurse

- Practical Nurse

- Aide, Orderly, Etc.

- Technician

- Administrator

- Other

INSTITUTIONAL

- Suppliers or Manufacturers
  - Blood
  - Instrument
  - Drug Manufacturer
  - Pharmacist
  - Machinery
  - Other

- General Hospital
  - Nonprofit
  - Governmental
  - Proprietary

- Psychiatric Hospital
  - Nonprofit
  - Governmental
  - Proprietary

- Extended Care Facilities
  - Nursing Home
    - Nonprofit
    - Government
    - Proprietary
  - Mental Health Center
    - Nonprofit
    - Governmental
    - Proprietary
  - Old Age Home
    - Nonprofit
    - Governmental
    - Proprietary
  - Rehabilitation Center
    - Nonprofit
    - Governmental
    - Proprietary
  - Ambulatory Care Facility (Other than Hospital)

  - Other

TABLE C-2
STATISTICAL PROJECTION OF APPELLATE DECISIONS

		SAMPLED PROJECTIONS				PREVIOUSLY PUBLISHED STUDIES							
		Aspen Systems Corporation				Sandor				AMA			
		California		United States		California		United States		California		United States	
		Pre 1950	Post 1950	Pre 1950	Post 1950	Pre 1950	Post 1950	Pre 1950	Post 1950	Pre 1950	Post 1950	Pre 1950	Post 1950
Highest State Court	Projected Total	28	15	391	150	*	*	*	*	*	*	*	*
	Adjusted by Proportion of Physicians to Total	17.9	7.7	251.0	77.7								
	Total Adjusted Proportions	25.6		328.7									
Intermediate Appellate Courts	Projected Total	90	42	350	129	*	*	*	*	*	*	*	*
	Adjusted by Proportion of Physicians to Total	57.7	21.7	224.7	66.8								
	Total Adjusted Proportions	79.4		291.5									
TOTAL Highest & Intermediate		105		620.2		101		677		100		605	
Ratio of $\frac{\text{Previously Published}}{\text{Sampled Projections}}$		——		——		.961		1.091		.952		.975	

* Highest and Intermediate State Court Subtotals Not Available on Comparable Bases

decisions and a number of total United States decisions falling between those reported by Sandor and the AMA.

There are two possible explanations for this very small difference. The Aspen Systems data included physicians representing the school of osteopathic practice, while both Sandor and the AMA studies expressly and apparently excluded them. In addition, the AMA study indicates some uncertainty as to the figure used for its 1955 data.[6]

It is estimated that if the cases dealing with claims against osteopaths were removed from the Aspen Systems data, its results would be almost identical to those published by the AMA. It is concluded that the sampling approach used in the Aspen analysis estimates with a remarkable degree of accuracy the numbers of reported cases when compared to these two exhaustive studies of the past in which each known case in the entire population was examined.

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[6] 164 J.A.M.A. 1349, "Court Decisions–Medical Professional Liability," July 20, 1957.

THE MALPRACTICE PROBLEM AND THE USE OF PHYSICIANS' ASSISTANTS

Eli P. Bernzweig, J.D.

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Background

The Federal Government has made a major commitment to the training of physicians' assistants (hereinafter referred to as PAs). In his Health Message of February 18, 1971, President Nixon stressed the need to train more personnel for these emerging forms of para-professional health care. The President stated:

> "One of the most promising ways to expand the supply of medical care and to reduce its costs is through a greater use of allied health personnel, especially those who work as physician's and dentist's assistants, nurse pediatric practitioners and nurse midwives. Such persons are trained to perform tasks which must otherwise be performed by doctors themselves, even though they do not require the skills of a doctor. Such assistance frees a physician to focus his skills where they are most needed and often allows him to treat many additional patients."

Responding to the President's request, Congress enacted legislation in 1971 to finance the training of PAs and the push for producing greater numbers of such individuals appears to be well under way.

Not only is the Federal Government financing the development of this category of health manpower, it is making concerted efforts to employ PAs within the Federal service. The Physician's Assistant is now a recognized occupational category in the U.S. Civil Service structure and it is anticipated that many PAs soon will be employed in hospitals and clinics operated by the Veterans Administration, Public Health Service, and the Armed Services.

As noted in the recent publication, *The Physician's Assistant Today and Tomorrow*,[1] the public media have also shown considerable interest in this phenomenon. Weekly magazines like *Time* and *Life*, the comic strip *Gasoline Alley*, and numerous television programs *The Bold Ones*, *Marcus Welby, M.D.*, and *Medical Center* have all featured PAs.

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[1] Alfred M. Sadler, Blair L. Sadler, Ann A. Bliss, *The Physician's Assistant Today and Tomorrow* (New Haven: Yale University Press, 1972).

This report was originally prepared as a background paper for the Secretary's Commission on Medical Malpractice, U.S. Department of Health, Education, and Welfare. Report No. SCMM-EB-PA.

What hopes will this new development fulfill in our nation's projected health manpower needs? The following six items are listed by the authors of the cited publication as the major benefits which the proponents of the PA concept think will result:

1) The PA holds out hope for a creative solution to our health manpower shortage.
2) PA programs hold great promise of providing useful civilian jobs to experienced returning military personnel.
3) The costs of health manpower education can be reduced.
4) The providing of health care services by non-physicians will save consumers money.
5) The PA can contribute to quality medical care by allowing physicians to see more patients under optimal conditions.
6) The PA is viewed as providing more manpower for primary, preventive, and emergency care needs.[2]

Whether some or all of the foregoing hopes will be fulfilled is problematical, but few can deny that the use of PAs has become a major hope in the development of a national health manpower strategy.

How Does the Use of PAs Relate to the Malpractice Problem?

Avoiding such collateral issues regarding the use of PAs as 1) their need, 2) their classifications and how they should be trained, 3) their potential effectiveness and productivity, 4) how they should be credentialed, 5) their career mobility, 6) their acceptance by physicians, hospitals, and the general public, and other similar issues, this paper will focus solely on the legal implications of their use and how the current malpractice environment may be affecting their utilization. We look first at some perceptions of the problem. Dr. T. F. Zimmerman of the Medical Education Division of the American Medical Association has delineated the problem thusly:

> "The legal implications, both civil and criminal, in utilizing new personnel and the need for careful articulation and supervision, are particularly significant factors in the present context of soaring costs of malpractice insurance paid by physicians. The physician incurs increased risk by using such personnel, for it is well established that an employer-physician is liable for injury caused by negligence of his employee, even if the employee is another physician."[3]

In testimony before the Secretary's Commission on Medical Malpractice on December 17, 1971, Dr. Frederick Hofmeister of the American College of Obstetricians and Gynecologists, pointed to the need for allied personnel in the obstetrical field, as well as the perceived legal problems:

> "In order to care for the increasing patient load, it is essential that allied health personnel become members of the health care delivery team. However, the obstetrician-gynecologist is reluctant to use allied health personnel until adequate protective mechanisms are formulated and until the state statutes recognize the expanded role of these personnel under the direction of the physician."[4]

A contrasting problem noted by the American Society of Anesthesiologists is the additional costs to physicians of malpractice insurance attributable to the use of PAs

> "The impact of the physician assistant on the cost of professional liability insurance has yet to be measured, but we can safely assume it will be substantial. For example, it is noted that in the State of Florida, even before a six-month experience with the now legally-constituted physician assistants has been developed, the price of malpractice insurance assessed against those who utilize such assistants, has been increased by $48.00 per year, and Florida is not by any means the most expensive state in which to buy malpractice insurance."[5]

The foregoing comments typify those of others in the health field.

A summary listing of the problems seen by health professionals in the actual or potential use of PAs would include the following:

1) In many states both the physician who seeks to use a PA and the PA himself will be subject to an increased risk of civil liability or possibly even criminal action.
2) Even where allowed by state law, the use of PAs will greatly increase the potential for harm to patients and will thereby increase the employing physician's professional liability.
3) Insurance coverage for PAs directly or for physicians who use them is either difficult to obtain or inordinately expensive.

All of the foregoing problems have acted as deterrents the use of PAs and will continue to do so in the future, thereby depriving the public of an effective form of auxiliary health manpower.

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[2] Ibid, pp. 13-16

[3] Joanna Buzek, (ed.) *Physician Support Personnel in the 70's: New Concepts*, p. 13 (Chicago: American Medical Association, 1971)

[4] U.S. Department of Health, Education, and Welfare, *Hearings*, before the Secretary's Commission on Medical Malpractice, Washington, D.C., December 17, 1971.

[5] Ibid.

It is readily apparent that these problems are interrelated, and this undoubtedly has compounded the problem of rational analysis of the several issues involved. The question of *legality of use* of PAs under existing state licensure laws is, by far, the most troublesome of all the issues presented, and therefore will be discussed first.

Is There an Increased Risk of Criminal and/or Civil Liability?

The PA has arrived on the scene in a period of great ferment in connection with the licensing of all categories of health personnel. How and whether they should be licensed is an issue clouded by antagonisms between competing health provider interests, in part due to selfish economic concerns, and in part due to genuine concerns about the quality of care.

As of December 31, 1972, some 25 states had either rejected proposed legislation according recognition to PAs, or had yet to consider the issue[6]. There is no question but that in any of these states the PA could conceivably be indicted for the illegal practice of medicine, and his employing physician could be charged with aiding and abetting the illegal practice of medicine. Although this type of criminal action is not highly probable, a few disquieting legal precedents would seem to indicate the need for statutory recognition of the PA. The most celebrated case on this subject is *People* v. *Whittaker*, Superior Court, Shasta County, California (1967), in which a former Navy medical corpsman was convicted of practicing medicine without a license while performing services as a surgical assistant to a neurosurgeon in Redding, California. Whittaker's physician-employer was convicted at the same time of aiding and abetting the illegal practice of medicine, and both convictions were subsequently upheld on appeal. *Whittaker v. Superior Ct. of Shasta County* 438 P. 2d 358 (Calif. 1968). No malpractice was alleged in this case, and no malpractice had to be shown in order to sustain the convictions. The California law simply had no provision for licensing—or otherwide recognizing—PAs at the time of the *Whittaker* case. In 1971, the California legislature enacted the California Physician's Assistant Act, Calif. Bus. & Prof. Code, Secs. 2510-22, which corrected the noted statutory deficit.

In a pending Michigan case, an osteopathic physician has been ordered to show cause before the State Licensing Board why his license should not be revoked or suspended for knowingly permitting an unlicensed person (in this case a PA graduate of the Duke University program) to treat patients of the physician. To our knowledge, no malpractice has occured or been alleged in the Michigan case, and neither the physician nor his PA have been indicted criminally.

These cases highlight the need for some form of legislative recognition of the role of the PA and his authority to carry out specific tasks under the direction of a duly licensed physician. The American Medical Association, American Hospital Association, and Department of Health, Education, and Welfare have recommended that all states enact amendments to their medical practice acts to codify the right of a physician to delegate tasks to PAs and other auxiliary health personnel.

It should be noted that criminal or other state legal sanctions against physicians and their PAs have nothing to do with the manner in which the PA performs. Thus, the problem—while admittedly serious and troublesome—is not a problem directly related to medical malpractice.

There are a few instances in which the lack of statutory recognition of the PA may become pertinent in a civil context: a) when actual harm has resulted, b) when a malpractice suit has been commenced against the PA, and c) when the violation of the State medical practice act gives rise to a presumption of negligence.

Whether an unexcused violation of a statute is conclusive on the issue of negligence is a question to which the responses vary by jurisdiction. In *Barber* v. *Reinking*, 411 P.2d 861 (Wash. 1966), a licensed practical nurse administered an injection and the needle broke off injuring the plaintiff. Since only physicians and professional registered nurses are permitted to give injections in Washington, the court held that one who undertakes to perform the services of a RN must have the knowledge and skill of a RN and the defendant's failure to be properly licensed raised an inference of negligence.

Despite the fact that cases of this sort are relatively rare, this case and others indicate that some courts may rigidly interpret the medical and nurse practice acts and rule against a defendant regardless of his professional qualifications or of the doctrine of custom and usage. This ambiguity could directly result in constraints on the employment and utilization of PAs and would provide further reason to enact appropriate legislation in states which have not as yet legitimized the PA.

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[6] Winston J. Dean lists the following states as having rejected legislation according recognition to physicians' assistants: Hawaii, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Nebraska, New Jersey, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and Wisconsin. He lists the following as states where such legislation was not considered: Louisiana, Maine, Mississippi, Nevada, New Mexico, North Dakota, Rhode Island, South Dakota, Texas and Wyoming. He notes, however, that several of these states will be considering such legislation in 1973. ("State Legislation for Physicians' Assistants: A Review and Analysis," *Health Services Report*, [Rockville, Md.: Health Services and Mental Health Administration, Department of Health, Education and Welfare, Jan. 1973] Vol. 88, pp. 3-12.)

Will the Use of PAs Increase the Potential for Harm to Patients and Thereby Increase the Physician's Overall Risk of Liability?

Thus far, no graduate PA has been sued for malpractice, but it is only reasonable to assume that before long cases of this nature will begin to materialize. There are those who predict the lawsuits will be all out of proportion to the actual harm, citing as authority the general malpractice climate and the growing tendency of trial attorneys to "sue every name on the chart."

We must carefully note the distinction between the PAs liability for his own conduct and the liability of his employing physician. Certainly, every PA will be liable for his own negligence under generally recognized principles of tort law. Whether the applicable standard of care will be measured against other reasonably prudent PAs or that of reasonably prudent physicians, remains to be resolved by actual court decision. It is logical to assume, however, that even application of the higher of the two standards of care will not give rise to litigation in the absence of negligently-caused injury and there are those who speculate that the incidence of injury will *decline* rather than increase with the use of PAs. The authors of *The Physician's Assistant Today and Tomorrow* state

> "In our view, the utilization of well-trained physicians' assistants who perform tasks within their capacity under appropriate physician supervision will *reduce* malpractice risks. We believe this for two reasons: First, effective utilization of PAs will allow the physician to concentrate on those medical procedures and judgments that only he can manage. Second, a malpractice suit often results from poor patient rapport rather than negligence *per se*. When a patient is seen after a considerable wait and then only hurriedly by a harassed physician, the probability of patient dissatisfaction is magnified. Time-motion studies have shown that, when a physician's assistant is used, waiting periods are reduced, patients receive greater attention from various health professionals, and patient acceptance of the PA has generally been good."[7]

The potential liability of the employing physician is three-fold. First, he can be held liable for negligence in the selection of his PA. Given the present circumstances in the training of such personnel (generally in university settings) the likelihood of negligent selection is almost nil. Secondly, he may be held negligent if he delegates a task to his PA which is beyond the latter's competence or experience, or fails to adequately supervise the PA. And finally, the physician may be held liable for the negligence of his PA under the doctrine of *respondeat superior*, which holds the master vicariously liable for the torts of his servants.

One purpose of the *respondeat superior* doctrine is to encourage physicians to maintain adequate supervision of their employees, while another is to provide the plaintiff a financially responsible party to sue. Insofar as the language of *every* PA statute stipulates that the PA will work under the direction, supervision, and control of the physician, there is little doubt that physician-employers of PAs do subject themselves to an increased potential risk of vicarious liability, but the risk seemingly is more one of a gross statistical nature (the more employees, the greater the exposure) than a *de facto* risk of negligent conduct. There is simply no basis for making any *a priori* judgments that PAs will perform their services in a substandard or negligent manner and expose their physician-employers to unwarranted liability under *respondeat superior.*

In short, the hiring and utilization of PAs creates no new legal liabilities on the part of physicians and their potential additional exposure to liability is less related to the *manner* in which their PAs will function than to the simple fact that the PAs necessarily will come into contact with more of the physician's patients. Presumably, the *quid pro quo* for this additional exposure is both greater income and greater productivity on the part of the employing physicians. Whether the potential risk of liability has in fact deterred physicians from utilizing PAs is examined in the material which follows.

Are Physicians and PAs Able to Obtain Malpractice Insurance Covering the Acts of PAs?

The Secretary's Commission on Medical Malpractice staff's study of PA programs[8] revealed that the insurance industry has made malpractice insurance coverage available both to PAs and to their physician employers. Although rates vary from state to state, a PA seeking his own coverage generally is charged a premium equal to one-half the premium charged his employer—an amount which various according to the medical specialty in question. Physicians generally are charged only nominal additional premiums for coverage of PAs roughly comparable to the costs of covering another office-nurse.

To illustrate these premium charges, in New York a physician (depending upon his rating classification) will pay between $12.50 and $26.00 extra for coverage of his PA. The PA himself will pay between $51.00 and $104.00. In the State of Washington, the physician will be charged $15.50, while the PA can obtain coverage for $62.00. These premium charges are for $5,000/15,000 coverage, and will increase proportionately for higher levels of coverage.

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[7] Sadler, Sadler, and Bliss, *The Physicians' Assistant Today and Tomorrow,* p. 83.

[8] See "The Effect of Fear of Litigation on Utilization of Physicians' Assistants." Infra, pp. 173 ff.

There is apparent consensus that all malpractice carriers will honor claims against PAs rather than disclaim liability under policy provisions relating to "illegal acts". This situation could arise, for example, if a court in a state in which the licensure problem has not been resolved were to rule that the unlicensed PAs conduct constitutes the illegal practice of medicine. In a brief telephone survey of major insurance companies, company officials stated they would not disclaim. They admitted, however, that the question had not yet arisen, and that actual cases might necessitate more thorough review of this question.

Is the Current Legal Environment Acting as a Deterrent to the Utilization of PAs?

A common assertion made about the use of PAs is that the fear of involvement in malpractice litigation has deterred physicians from using them. The roots of this fear have been outlined earlier in this paper, and the only remaining question is: how valid is the assertion? Are physicians in fact refusing to employ these individuals for the legal reasons stated?

The Commission's staff study on this issue[9] surveyed 22 representative PA programs around the country on the vital question of the employment and utilization of graduates of these programs. Of the 473 graduates of non-Federal programs 421 (89%) have been employed in the patient care field. Of the 52 who have not been so employed, 15 have continued their schooling, 19 have decided upon other types of employment, and only 7 (1%) are unemployed and seeking employment.

If nothing else, these figures repudiate the common assertion that PAs are not being utilized by physicians because of legal concerns relating to the current malpractice environment. Apparently, PAs are being employed as rapidly as they can be turned out, and thus far they have been employed in 44 states. There is no doubt that many physicians *believe* the use of PAs will expose them to additional risk of liability, and may be reluctant to utilize them for this reason. The fact remains, however, that at the present time the demand for PA services far exceeds the supply, and those practitioners who have begun using them apparently have less concern about legal liability problems than their colleagues.

Some PA program directors have voiced concerns about the placement of graduates in states without PA-authorizing statutes, but the Commission's study reveals that the major perceived impediment to the maximum utilization of PA's has nothing to do with the malpractice environment. Rather, the program directors place the principal blame on the health care community's general reluctance to accept this new breed of health personnel as members of the health care team.

Conclusion

Based upon the foregoing, it appears that the only significant legal impediment to the effective utilization of PAs is the absence of authorizing legislation in the 25 states which currently do not recognize PAs in their statutes. There appears to be no significant or unique malpractice liability imposed upon a physician who employs a PA, nor any greater liability imposed upon the PA himself. It would appear, therefore, that alleged concerns that PAs are not being effectively integrated into the health care system because of malpractice problems are without foundation. Perhaps the greater problems relating to the more widespread acceptance of the PA concept relate to 1) the attitudes of physicians themselves, 2) matters pertaining to the training and credentialing of PAs, 3) economic concerns of the medical and nursing professions, and other non-medical-legal issues.

That physicians are not as reluctant to utilize PAs as some have said is evident from the Commission's study which shows that approximately 89% of all graduated PAs have been employed in patient care activities in 44 states throughout the nation.[10] It would seem that the time has come to lay to rest the common assertion that PA's are not being effectively integrated into the health care system.

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[9] Ibid.

[10] Ibid.

THE EFFECT OF FEAR OF LITIGATION ON UTILIZATION OF PHYSICIANS' ASSISTANTS

H. Beth Marcus, M.A.

Summary

The fear of medical malpractice litigation arising out of the doctrine of *respondeat superior* appears to have resulted in little detrimental effect on the employment and utilization of the physicians' assistants. Although resistance to the concept of physicians' assistants exists, the graduates of physicians' assistant programs are finding positions throughout the country which utilize their ability. While the survey responses indicate that the fear of litigation does exist, the responses also suggest no evidence that this is justifed. No legal action has been taken against a physician's assistant or his employer, and malpractice insurance is available, if expensive, for this new group of health care personnel.

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Introduction

In his charge to the Commission, the Secretary asked the Commission to investigate the entire range of problems associated with professional liability claims against all categories of health care providers and institutions. During the Commission's hearings, and through statements received from major health interests in the country, a variety of potential legal problems relating to the use of physicians' assistants was brought to the attention of the Commission.

This report was originally prepared as a background paper for the Secretary's Commission on Medical Malpractice, U.S. Department of Health, Education, and Welfare, Report No. SCMM-HM-PA.

This study represents an attempt by the Commission to assess the impact of the malpractice environment on the use of this emerging form of auxiliary health manpower.

Background

This nation has recognized its health manpower shortage for a number of years and has tried to come to grips with both the number and distribution characteristics of that problem by diverse means. One such effort has been the initiation of a series of physician's assistant (PA) training programs, a physician assistant[1] being defined by the House of Delegates of the American Medical Association as "a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician, who is responsible for the performance of that assistant." As of June, 1972, 84 PA programs have been initiated and these programs are distributed across the various medical specialities.

With the creation of a new member of the health care community whose function is to provide some of the lower level primary care services which task-load physicians, certain legal issues arise. Notable among them is the doctrine of *respondeat superior.* This doctrine places the liability for damages accruing from injuries arising out of the negligence of employee paramedical personnel on the practitioner by whom they are employed. While some Medical Practice Acts are broad enough to permit the use of new support personnel,[2] the absence of express authority for the use of PAs in a number of jurisdictions could intensify the legal complications which might arise from their use in those jurisdictions.

It has often been asserted that the fear of malpractice litigation arising out of the supervisory role of the practitioner has resulted in the widespread unwillingness of practitioners to employ and/or utilize physicians' assistants. A Duke University study, for example, indicated that while 60% of the physicians surveyed believed that additional help is necessary, only 30% said they would hire a physician's assistant. The results of surveys conducted independently by the American Academy of Orthopaedic Surgeons and the American Urological Association, however, indicated a differing viewpoint. The conclusions drawn from these surveys suggest that the members of both the American Academy of Orthopoedic Surgeons and the American Urological Association have a strong desire to employ and utilize support personnel.

While the allegation has been made that the *respondeat superior* doctrine has discouraged the physician from hiring the PA, previously conducted studies on physician's attitudes have resulted in conflicting conclusions. The major concern of this study was also to determine how much effect the question of possible future malpractice litigation has had to date on the hiring and utilization of PAs by physicians. The difference between this study and the three studies previously cited is that the people surveyed in the current study were not physicians, but rather directors of the major PA programs.

Method

Survey questionnaires were sent to 22 PA training programs. Six of these programs were labelled physician's assistant programs, 4 were MEDEX programs, and the remaining 12 represented the following specialty areas: orthopoedic assistant training program (3), surgeon's assistant program (2), urological assistant training program (1), pathology assistant program (1), child health associate program (1), master life supports system technology (1), clinical corpsman training program (1), and medical emergency technology (1).

The selection of these 22 programs was based upon a universe of those programs which as of April, 1971 expected to have graduated students by August, 1972. From the 22 programs, 21 completed survey questionnaire's were received. Although the survey results indicate that 3 of the 21 programs have not graduated students as of that date, all of the 21 programs have students employed in the profession either as training assistants or as graduates of a PA program.

The survey was composed of 19 questions. These questions were formulated around five general topics: 1) a description of the program, 2) the hiring practices of the PA employer, 3) the utilization of physicians' assistants, 4) professional liability and legal concerns regarding their utilization, and 5) self-initiated studies of PA employment.

Results

A. A DESCRIPTION OF THE PROGRAM

The PA programs have only been in existence for a short period of time. The first year in which there were graduates from PA programs was 1967—and only one school had a graduating class in this year. In 1969, four schools had graduating classes; in 1970, one program had its first graduating class; in 1971 there were four programs which graduated their first classes; in 1972, ten programs had their first graduating classes; and one program noted 1973 as the expected year for their first graduating class. The total number of graduates of the 18 PA programs that have had a graduating class as of August, 1972 is 488. The mean size of the last graduating class for the 18 schools which had graduates was 14.

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[1] Other terms are sometimes also used to denote the concept (e.g. physicians' extenders).

[2] The states which provide exceptions to their Medical Practice Acts which codify the physician's legal right to delegate routine patient care functions to qualified nonphysicians are: Alaska, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Kansas, North Carolina, Oklahoma, and Utah.

The states which give their State Boards power to approve programs and authorize a physician's use of no more than two graduates of PA programs are: Alabama, California, Florida, Iowa, New Hampshire, New York, Oregon, Washington, and West Virginia. The states in which this legislation is pending are: Illinois, Indiana, Maryland, Michigan, Minnesota, Nebraska, Ohio, Georgia, Hawaii, Kentucky, Pennsylvania, Tennessee, and Wisconsin.

B. HIRING PRACTICES

All but one of the programs indicated that they assist graduates in job placement. The most frequent methods through which this is accomplished are, in order of decreasing frequency of responses: maintaining lists of openings; providing counselling and support services; and maintaining files of the students' own efforts.

Four hundred seventy three students have been employed in the PA field, this number including both graduates and in-training students who expect to continue in their positions upon completion of their program. Most of these people accepted positions which call for direct patient contact under a physician's supervision. Of the 52 graduates who have not been employed in a PA position, 19 have obtained positions in other fields, 15 are taking advanced schooling, 7 are unemployed (some of whom are awaiting interviews or are unemployed due to personal choice), 2 are deceased, and 9 are not accounted for.

The geographic dispersion of the working graduates and students in training is fairly widespread with 44 states currently having PAs employed within their boundaries, plus those to be found in the District of Columbia, the United States Air Force, and Africa. Of the 473[3] who have accepted jobs, 306 (64.7%) have stayed in the state in which they went to school and 47 (9%) went to bordering states. One hundred six (22.4%) graduates took jobs beyond the neighboring states in which they attended school. The states in which the largest number of graduates were hired were Washington (65), New York (65), North Carolina (41), and Ohio (35). Those states with the greatest variety of schools represented by their employed PAs were Iowa, with 6 schools represented, and Ohio, with 5 schools represented.

An attempt was made to determine the rationale used by the physician-employer for hiring assistants. The directors of the physicians' assistants programs ranked the four alternatives given them in the following order: a) reduction of the physician-employer's workload; b) increased effectiveness of patients' care; c) increasing the number of patients seen and the resulting economic benefits to the employing physician. There was a high consistency in this response pattern.

C. THE UTILIZATION OF THE PHYSICIAN'S ASSISTANT

The survey asked the PA program directors to state what they considered to be the most difficult problem that needs to be overcome in order to achieve maximum utilization of the physicians' assistants in the United States. The responses for this question grouped into three categories. The most frequently indicated response dealt with the attitude of the physicians and other health personnel toward the physician's assistant, specifically the non-acceptance and poor utilization of the PA by the health care community. Confusing and inadequate legislation dealing with PAs was the second most frequently mentioned problem. The third problem cited was the nonacceptance of the PA by the public due to its lack of understanding of a PA's function.

D. PROFESSIONAL LIABILITY AND OTHER LEGAL CONCERNS

Of the 21 responses, 4 knew of a specific instance in which the possibility of malpractice litigation has been a prime factor in creating difficulty in a PA's placement. None of the graduates have themselves had any difficulty obtaining medical malpractice insurance, with two-thirds of the graduates obtaining this insurance either from a physician or institutional employer.

Seven of the respondents, however, did suggest concern with the legal aspects of the employment of their graduates in specific states. The fear of litigation by employers was indicated by 6 of the program directors, with the states of Alaska, New York, New Jersey, Pennsylvania, Connecticut, California, and Ohio cited as the states in which this situation exists. The absence of authorizing legislation, indicated by 4 of the respondents, was found to be a problem in Alaska, Indiana, Kentucky, New York, New Jersey, Pennsylvania, Connecticut, and Ohio. California, New York, New Jersey, and Oregon were mentioned as states in which there were professional barriers. The responses indicated that this was also true in 3 other states, though they were not named. According to 2 respondents, California and Kentucky were the only states in which there appeared to be no need for physicians' assistants. California was cited by one respondent as having state statutory laws prohibiting the use of the PA. None of the respondents knew of any individual graduates who had been prevented from receiving a position because of a lawsuit to prevent practicing, a threat of lawsuit, or criminal prosecution.

Seven of the 21 program directors had investigated possible legal barriers in specific states. The most common way in which these restrictions were determined was through a review of statutory provisions. The second most frequent means of determining this was the requesting of an opinion from the attorney general, the state medical legal council or the state board. These checks led to the discovery of legislative restrictions in Alabama, Alaska, California, Colorado, Idaho, Ohio, New York, and Washington. In Colorado and Ohio these restrictions specifically involved the child health assistant and the surgical assistant programs. The general restrictions of the legislation was mentioned in Alaska and Idaho. In the other 4 states more specific restrictions were indicated. In Alabama it was stated that the physician's assistant cannot operate a satellite clinic and a physician must practice for 5 years before he can hire a physician's assistant. Washington has implemented a moratorium until an evaluation of the PA program is established. In California it was noted by one respondent that the Physician's Assistant Act had not been implemented by the State Board of Medical Examiners to date and as a result the PAs in California have no legal status.

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[3] The locations of 12 graduates from the Duke University Physician's Assistant Program and 2 graduates from the Borough of Manhattan Community College Medical Emergency Technology Program are unknown.

E. SELF-INITIATED STUDIES OF PHYSICIAN'S ASSISTANT EMPLOYMENT

While some of the PA programs are considering initiating studies concerning their graduates, of the 22 programs only one, the Duke University Physician's Associate Program, has completed a formal report. The Duke report adds further information to the overall study of PAs.

According to the Duke study, professional liability insurance is available to the PA on his own or through his physician-employer or institution-employer. While the rates vary from state to state, usually the physician's assistant pays approximately 50% of the fee paid by his supervising physician for similar coverage. The added cost to the physician is very small.[4]

Discussion and Conclusions

The survey results indicate that the fear of litigation has not to date had a serious detrimental effect on the PA. Recently graduated PAs are being hired with only 1% listed as unemployed. PAs have also obtained employment throughout the country, with 44 states and the District of Columbia as areas in which physicians' assistants have been hired.

It would appear that the PA is being employed in a capacity which permits him to fulfill his prime function—performing some of the lower level tasks which burden the physician. The types of jobs the PAs have accepted for the most part directly involve patient contact and are under a physician's supervision. The survey results have indicated that most program directors believe that the prime reason for a physician hiring an assistant is the reduction of his workload.

The PA programs are meeting with some resistance, but this is primarily due to the nonacceptance or lack of understanding of the PA job on the part of physicians and other health care personnel, and to legislative restrictions, rather than to fear of litigation. According to the survey respondents, many physicians and other health care personnel are reluctant to accept someone who has had less training than they have had. The legal restrictions appear to relate primarily to complex and confusing laws regulating the PA which delay the creation of PA programs and limit the capacity in which PAs may be employed.

In regard to the area of medical malpractice insurance, the PA has had no difficulty obtaining insurance. As the Duke study indicates, the liability coverage is available either for the PA as an individual or in his capacity as an employee. Malpractice insurance premium rates for PAs, however, appear to be somewhat higher than rates for other supervised allied health care personnel.[5]

There has been no record of any individual graduate being involved in a lawsuit or criminal action regarding his position. At present, then, there has been no situation in which malpractice litigation has involved a graduate of a PA program.

In drawing conclusions from the survey results, however, it must be emphasized that the number of PA programs and PAs employed in the field is very small. Even if, as the Duke study suggests, only 30% of physicians would hire a PA, it is obvious that at present the demand for PAs is much greater than the supply. It is possible that when the supply and demand become more equalized and the number of employed physicians' assistants is much greater than 473, problems may arise which were non-existent or minimal when the concept was initially created. However, it is also likely that when the programs have been in existence for a longer period of time and they are more established and accepted, physicians may become less reluctant to hire PAs.

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[4] Duke University Medical Center, "Information Brochure" Durham, North Carolina, page 9.

[5] "Medical Malpractice Problems of Non-Physician Health Care Personnel as Reflected in Professional Liability Insurance Rates," *Infra*, pp. 644ff.

ACCESS TO MEDICAL RECORDS

Dennis Helfman
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Susan Lutzker
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Introduction

The present study collects, analyzes, and presents legal materials on Access to Medical Records.

The major headings of the material following are: Analysis, Summary and Collation of the State-by-State Study; Summary of Legal Literature; Selected Legal Bibliography; Selected Medical Bibliography; Suggestions for Future Study and The State-by-State Study.

The areas of inquiry selected for the State-by-State study were Physician-Patient Privilege; Public Records Acts; Medical Lien Acts; Required Reports; and Special Access Laws. These heading are used in this Introduction and in the Analysis, Summary, and Collation as well as in the State-by-State Study itself.

The State-by-State study contains a presentation of relevant statutes and cases. The Appendix contains a graphic tabulation of the results of the State-by-State Study.

This Report was prepared for the Secretary's Commission on Medical Malpractice, Department of Health, Education, and Welfare under Contract No. HEW-OS-72-136 with Georgetown University Law Center. Report No. SCMM-GL-AR.

ANALYSIS OF THE BASIC LAW IN THE ABSENCE OF SPECIAL PROVISIONS

In the absence of special provisions or principles, medical records are the property of the doctor or a hospital maintaining them. However, the bundle of rights connoted by the word "property" never includes the right to do absolutely anything one wishes to do with his own property. For example: One's right to one's own automobile does not include a right to use the automobile to injure another; and in the case of medical records, the hospital cannot use the records in violation of the patient's right to privacy.

As with any property, the hospital and doctor's property right to the records is also qualified by the obligation we all have to produce our property if required pursuant to judicial process (e.g., a subpoena) for purposes of a law suit (either pretrial discovery or as trial evidence).

Property in records, be they business records or otherwise, is often qualified by another duty placed upon their owner: A duty to record certain information; to maintain and keep those records for a certain number of years; and to keep them open for inspection by certain regulatory agencies. Such is the case under the corporation laws of many states; under the Federal Securities Exchange Laws (respecting stock brokers); under departments of health laws in various states (respecting licensed hospitals); and under other regulatory and licensing schemes.

Because the property rights in medical records possessed by the doctor or hospital are those of the doctor or hospital, a doctor or hospital may refuse to disclose them to the patient or his legal representative, in the absence of court process or special law.

FIVE HEADINGS USED IN THE STATE-BY-STATE PRESENTATIONS

Physician-Patient Privilege

A legal prohibition against disclosure in litigation of confidential medical matters did not exist at common law, despite the existence of similar prohibitions governing marital and legal confidences. However, forty-three states today have enactments providing some form of such prohibition. Although variously phased as an incompetency, prohibition, or privilege, the provision is nearly always construed as a privilege. That is, it may be asserted or waived by the patient or by someone on his behalf (e.g., the court, a lawyer, or the doctor or hospital). The primary impact of this "doctor-patient privilege" is at trial and during pre-trial discovery. In the absence of some special privilege such as this, it is basic law that documents or information in the possession of anyone must be surrendered if required by proper court process for the resolution or preparation of a controversy in litigation pursuant to valid discovery process or subpoena (subpoena duces tecum for documents) or similar court order or process, for purposes of pretrial discovery or trial evidence.

A proposal for a uniform body of Federal Evidence Rules presently pending before the Supreme Court of the United States provides only for a psychotherapist-patient privilege, and no general doctor-patient privilege.

In a malpractice action, questions of privilege can arise in a number of ways. They can arise where the plaintiff or defendant is seeking records of a third party (e.g., to show the customary or non-customary nature of a procedure performed on the plaintiff, or to impeach the word of the third party as a witness). If the plaintiff himself is seeking his own records, the privilege will be waived insofar as his own access is concerned. If the defendant is seeking the plaintiff's records, the better (but by no means settled) view would be that plaintiff by instituting the action has waived his privilege as relevant records.

Public Records Acts

Many States have so-called "Freedom of Information" acts providing that documents in the possession of state agencies shall be open to public inspection. As there are numerous state-run hospitals or medical facilities, the question arises as to whether medical records of patients therein are required to be open to the public. In most states, however, medical records are exempted from the acts.

Lien Laws

Many states have statutes designed to help secure that a hospital treating a patient will receive payment therefor. These statutes provide that a hospital shall have a lien on amounts collected from a wrongdoer by the patient for his injury. In some states, not only hospitals, but treating physicians as well are accorded such a lien. The medical lien statutes generally provide that the hospital treating the injured person shall file notice of its charges in a public office or otherwise notify the injuring party of its charges and that if this is done, the hospital is entitled to receive its charges as a first priority (before the injured party gets anything) out of any settlement or recovery payable by the injuring party to the injured party. If the injuring party pays the injured party before the hospital charges are satisfied, rather that the hospital, the injuring party is liable to the hospital. The significance, for our purposes, of these laws is that they often permit the injuring party (i.e., the party notified of the lien or against whom the lien is asserted) to examine the hospital records of the injured party. The purpose of this is to enable the bona fides of the hospital's claim to be checked over and verified; but in a number of states, the authorization to inspect is not limited to financial records.

Required Reports

Certain medical conditions may be required by law to be reported to a government agency by the treating physician or the patient (e.g., venereal disease, "battered" children, gunshot wounds or other violent injuries). As the entire medical background of a patient may become relevant in a medical malpractice action, these state agencies may be approached by a party or potential party to such an action, for information filed in a required record. The question arises as to whether and to whom these records will be disclosed by the agency.

Special Access Laws

Nine states have statutes specifically dealing with a patient's right of access to his medical records aside from any rights he may have under court process once litigation has commenced. Typically such statutes provide that the patient or his expressly authorized representative must be given access to his records. This heading also includes certain other legal matters in particular jurisdictions bearing on accessibility of medical records.

Analysis, Summary and Collation of the Results of the Study

I. PHYSICIAN-PATIENT PRIVILEGE

The physician-patient privilege, unlike that of attorney-client, did not exist at common law. However, 43 states and the District of Columbia, in order "to encourage confidence and preserve it inviolate" (Idaho Code §9-203; *see also* preamble to Montana and Utah provisions) have enacted statutes protecting from disclosure confidential communications between physicians and their patients (Connecticut, Florida, Kentucky, Maryland, Georgia and Tennessee restrict the privilege to psychiatrists. Alabama, Delaware, Rhode Island, Massachusetts, South Carolina, Texas and Vermont are the seven states having no general doctor-patient privilege statute).

Testimony v. Disclosure

Most of these laws state that a physician or surgeon may not be examined in a legal proceeding as to confidential patient communications. This type of language is susceptible to the interpretation that it applies only at trial, but courts have interpreted it to include discovery proceedings (depositions) as well.

The statutes of at least eight states speak of "disclosure" rather than testimony. The more recently-enacted statutes of California and Nevada afford the patient "a privilege to refuse to disclose, and prevent others from disclosing" confidential information.

"Communications" Defined

Usually, privilege statutes apply to communications by the patient to the doctor and/or information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient (e.g., North Carolina). The scope of the privilege is left in question by some statutes, such as that of West Virginia, which mentions only communications made by the patient to the doctor. Interpreted narrowly, this could mean only oral communications and not other medical records or information about the patient's condition acquired by other means such as tests or physical examination. If test and examination results are deemed "implied communications" from the patient, there are still sources of information that may not be covered, e.g., sources other than the patient, but relating to the patient's case.

California's definition of confidential communication is quite elaborate, encompassing:

> "information, including information obtained by examination of the patient, transmitted between a patient and his physician in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses to no third persons other than those who are present to further the interest of the patient in the consultation or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the physician is consulted, and includes a diagnosis made and the advice given by the physician in the course of that relationship."

(CAL. EVID. CODE §992 [West Supp. 1971]).

The privilege is most narrowly applied in New Mexico (communications as to venereal or other "loathsome disease"), Kentucky (vital statistics) and Pennsylvania (information that tends to blacken the character of the defendant).

Many of the privilege statutes are explicitly limited to civil actions. Even if such a state has another statute or rule providing as a general matter that the rules of evidence applied in civil actions shall also apply in criminal cases, courts have held that the words "in civil actions" in the privilege statute indicate a legislative intent not to extend the privilege to criminal cases, especially since the privilege is in derogation of the common law (e.g., Montana and Oregon).

Exceptions

Many of the privilege statutes contain exceptions, the most significant of which is the automatic waiver of the privilege where the party's physical or mental condition is an element of a claim or defense or where the party's physical condition is in controversy. Such a statutory exception is applicable in at least twenty states, including Connecticut, New Jersey, Illinois, Michigan and Wisconsin. Five states (California, Colorado, Illinois, Michigan and Wisconsin) maintain a separate exemption for malpractice suits, although malpractice actions in other states would probably fall under the "physical condition in issue" exception.

The laws of Maine and Tennessee simply allow a court to compel disclosure where it deems it necessary for a proper administration of justice.

Many statutes explicitly provide that the privilege is waived if the party testifies as to the confidential communication or puts a physician on the stand to testify as to the party's physical or mental condition. In the absence of such a statutory provision, case law has frequently held that the privilege is waived by such testimony (See below).

Laws requiring the reporting of cases of suspected child-abuse also often provide for waiver of the privilege in proceedings concerning such cases.

Other situations where the privilege is waived by statute are proceedings to commit or establish competency, proceedings to test the validity of a will, proceedings involving the unlawful attempt to procure narcotics, actions to recover damages for a criminal act, and cases where the medical services were sought in an effort to commit a crime or tort. (California's statute includes the most comprehensive list of exceptions).

Recently, at least seventeen states have enacted special laws relating to psychologist-client or psychiatrist-patient communications. Because of the nature of such communications, these statutes create a much more comprehensive privilege, either placing them on the same ground as the attorney-client privilege or providing a blanket exemption from disclosure in both civil and criminal actions with few or no exceptions—the most common of which is where a defendant raises a defense of insanity. Some statutes extend this psycho-privilege to communications with members of the patient's family or members of group therapy sessions.

Waiver

There are different ways of waiving the physician-patient privilege besides the specific statutory exceptions mentioned above. Most of these methods are derived from the case law rather than from the statutes. All of these waivers are variations of the voluntary waiver by the holder of the privilege. The reasoning behind any of these waivers is to prevent the holder of the privilege from having an unfair advantage in a lawsuit. If the holder of the privilege could selectively put on testimony and by claiming privilege prevent his opponents from countering it, the handicap would probably be too great to overcome.

In some states, the mere commencement or filing of a suit in which the patient's physical or mental condition is at issue constitutes a waiver of the privilege (e.g., New York). In others, filing is not a waiver, but the waiver is not postponed until the patient introduces testimony at trial relating to his physical condition. Instead, it is accelerated so that the opposing party may investigate the claims of the patient during the discovery process (e.g., Ohio). Some states permit depositions to be taken, including questions on privileged matters, but permit the patient to invoke the privilege later on in the suit (Michigan). But other states do not require a waiver until a physician is called as a witness and examined directly (e.g., Iowa). Whether this applies to depositions as well as trial testimony is not clear. Most states also regard a waiver of the privilege as to one physician as a waiver of the privilege for all the physicians who treated the patient (e.g., Arkansas).

Thus, the time for a waiver, as construed by the courts, ranges from the moment of filing to the time when a physician is examined directly as a witness. The competing interests of confidentiality and fairness to opposing litigants have been reconciled differently by the state courts and the question remains open: At what point in a lawsuit to recover damages for personal injuries or malpractice should the privilege be waived?

II. PUBLIC RECORDS ACTS

Most states have statutes requiring that public records, that is, records kept by governmental bodies, be open for public inspection (see Arkansas's "Freedom of Information Act").

Fifteen states specifically exempt medical records from the provisions of the inspection acts.

The statutes of five states merely include language generally exempting records otherwise required by law to be kept confidential (e.g., Nevada). All of these states have physician-patient privilege statutes which would seem to bring most medical records under this exception.

Some states only exempt specific types of medical information on file with government agencies such as records of patients in state or county hospitals (Tennessee and Ohio), records of patients receiving state medical assistance (Tennessee), and reports of injuries suspected to be caused by violence (Oregon). Required reports statutes also frequently contain limitations as to what persons may review them.

Over one-half of the states do not specifically exempt medical or confidential records from their open records acts.

III. MEDICAL LIEN ACTS

Most states have hospital (and some have physicians') lien statutes which allow the hospital or doctor to assert a lien on any judgment rendered against a person liable for the injuries for which the injured person was hospitalized and thus to collect for their unpaid bills.

The hospital lien laws of thirteen jurisdictions allow the party against whom a lien has been asserted to examine the hospital records relating to the services furnished the injured person.

In three jurisdictions - Colorado, Maine and the District of Columbia, - inspection is restricted to financial records. In Maryland, inspection is permitted "to ascertain charges and estimate the lien" suggesting that inspection is actually limited to financial records. Most statutes, however, refer only to "hospital records" in general leaving open the question of what kind of records fall under the Act. Illinois' law also permits the defendant to request and receive a written statement of the nature and extent of the injuries sustained by the plaintiff, the treatment given him, and how the injuries were received (if stated by the injured person and contained in the records).

Most of the states with such lien acts either have no physician-patient privilege statute or waive it automatically in personal injury actions.

IV. REQUIRED REPORTS

Most states require that two types of medical problems be reported to the appropriate governmental agency -

venereal disease and suspected cases of child abuse.

Most of the child-abuse statutes also include provisions stating that the physician-patient privilege does not operate to exclude from evidence such reports. Usually physicians and others reporting such cases are granted immunity from civil liability for testifying and reporting.

Almost half the states which require reports of cases of venereal disease protect, to a greater or lesser degree, the confidentiality of such reports. The most protective require that doctors report cases by code number only. In other states, the reports are not open to public inspection but may be seen only by specified health officials.

Many states also require physicians and hospitals to report tuberculosis and other types of contagious diseases, but the identity of patients usually is protected from public disclosure.

Other types of medical reports occasionally required are cancer, drug addiction, injuries inflicted by violence and cases of occupational disease. In the case of drug addiction, the trend is to create complete confidentiality and immunity for those who seek treatment.

V. SPECIAL ACCESS LAWS

Statutes

Only nine states have statutes specifically allowing patients or their attorneys to inspect hospital medical records. Of these, the statutes of California, Illinois and Utah permit records to be examined and copied by the patient's authorized attorney only, not by the patient himself. However, the statutes of the six other states explicitly or implicitly allow access to the patient himself (e.g., Massachusetts, New Jersey and Wisconsin). The statutes of California and Wisconsin include sanctions for refusal to disclose. Thus, California's law requires that patients be reimbursed for all legal expenses, including attorneys' fees, in any proceeding to enforce the provisions of the statute; while Wisconsin requires the custodian to pay all necessary costs of obtaining the records plus up to fifty dollars in attorneys' fees.

The statutes vary somewhat in their details. California's statutes specifically allow access prior to the filing of an action. Connecticut permits records to be examined only after the patient has been discharged. In Louisiana, a patient or his attorney is authorized to get a "full report" suggesting something less than a look at the original records. Mississippi requires a showing of "good cause." New Jersey permits access to plaintiffs and defendants in personal injury suits.

Many of these access statutes state that their provisions are inapplicable to the records of mental patients whose records are governed by separate laws and regulations.

Many states are by statute explicitly protective of the confidentiality of the records of patients in state mental institutions. Usually the disclosure of their records is prohibited by law except (1) on the consent of the patient, (2) by consent of the hospital director as necessary for the treatment of the patient, (3) as a court may direct upon determination that disclosure is necessary for the conduct of proceedings before it and that failure to disclose would be contrary to the public interest, and (4) in hospitalization proceedings upon request of the patient's attorney (e.g., Kansas).

Case Law

Cases directly touching on the right of access to hospital records are uncommon. A federal district court in Oklahoma has held that a patient has a property right in information in his hospital records and he, or someone authorized by him, has a right to inspect and copy those records without the necessity of resorting to litigation. The New York Supreme Court held that a hospital cannot withhold a patient's records from him when he wishes to determine, for the purposes of a malpractice claim, which doctors operated on him or treated him.

In Ohio, the Supreme Court has held that a hospital may permit a patient to see as much of his hospital records as the hospital feels is in the beneficial interest of the patient. If unsatisfied with the scope of the inspection, the patient may institute a court action to require the hospital to furnish the entire record.

Regulations

Considering the absence of statute or case law, access to hospital records in most states is governed by regulations of state hospital licensing agencies. These regulations were difficult to obtain, but the results are sufficient to indicate the types of administrative provisions encountered.

Where a regulation makes reference to the ownership of hospital records, it generally places title to the records in the hospital. This appears to be a narrow view, the better approach being that the hospital and the patient each have an interest in the records of the patient. Few states have recognized the interest of the patient, however. In many instances, whether permitted by regulations or in the absence of any contrary regulations, individual hospitals establish policies governing access to hospital records, the vast majority of which are quite restrictive.

The regulations fall into two general categories. Some allow inspection on the written consent of the patient, with the patient, other persons (i.e., attorneys) or both being allowed to inspect the records.* Under this type of regulation a patient or his attorney could inspect his hospital records to determine whether he should institute a lawsuit. All states permit inspection of hospital records (other than mental hospitals) upon court order, obtainable after a lawsuit has been commenced. If neither regulations nor the policies of the individual hospital, if applicable, provide for inspection by the patient presumably the filing of a lawsuit would be a prerequisite to inspection, which could be accomplished by resorting to state discovery procedures.

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*The rationale for allowing access to the legal representative and not the patient, found in some of the access statutes and regulations and hospital practices, is that there are some medical matters which the patient may not understand or should not know in the interest of his health.

Summary of Legal Literature

Law review articles and commentators address themselves to four areas of concern relevant to this study. These are: (1) physician-patient privilege; (2) in a malpractice action the defendant-physician's access to plaintiff-patient's prior and subsequent medical records where plaintiff has asserted physician-patient privilege; (3) possible remedies to protect the patient against unauthorized disclosure by physicians of medical secrets outside the courtroom; and (4) patient's access to his own medical records.

PHYSICIAN-PATIENT PRIVILEGE

Professor Wigmore's scathing denunciation of the physician-patient privilege remains its definitive criticism.[1] His argument, which permeates the literature on the subject, is that the physician-patient privilege does not satisfy the four fundamental conditions which he deems essential to every privilege for communication, i.e., to every exception to the general requirement that every person testify as to all facts inquired of in a court of justice. These conditions are: (1) the communication must originate with the expectation of confidentiality; (2) the element of confidentiality must be essential to the satisfactory maintenance of the relationship between the communicating parties; (3) the relationship must be one which society seeks to foster; and (4) the harm from disclosure must be greater than the expected benefit to justice gained by admitting the testimony.[2] Professor Wigmore submits that with the exception of the third condition, none are satisfied in the physician-patient relationship.

As to the first, he argues that with the exception of loathsome diseases or abortion, few if any patients attempt to preserve any real secrecy. As to the second, he maintains that even where a patient does expect confidentiality, he would not be deterred from seeking medical assistance because of the possibility of future disclosure in court. And as to the fourth, he emphatically argues that the injury to justice is far greater than the injury to the relation.[3] Ninety-nine per cent of the litigation in which the privilege is invoked, he maintains, involves either personal injury cases—in which the patient has voluntarily brought himself into court and placed the extent of his injury at issue—actions on life insurance policies where the deceased allegedly misrepresented his health to the insurer, and testimentary actions where the testator's mental capacity is being questioned.[4] In none of these can there be any fear that the absence of the privilege would hinder people from consulting physicians freely; in all of these is the truth as to the medical questions an absolute necessity if justice is to be served.[5]

In short, concludes Professor Wigmore, there is little to be said in favor of the privilege and much to be said against it.[6]

He suggests as a modest improvement in the present law where the privilege exists, to adopt the North Carolina rule which allows the court to require disclosure when justice demands.[7] Another modification of the physician-patient privilege that has been proposed is to adopt the three conditions that Professor Wigmore argues are usually not met in the physician-patient relationship into a new privilege statute; when the conditions are satisfied, then the physician-patient privilege—as well as any other types of communication that meet the conditions—would apply. The proposed statute requires a case-by-case determination on the facts by the trial court as to whether the conditions have been met; it explicitly forbids consideration of case precedent concerning the type of relationship involved (e.g., physician-patient, attorney-client, etc.).[8] A third proposal for modification of the physician-patient privilege is to exclude it when the condition of the patient is a factor in a claim or defense at trial.[9] Another suggests an inference of adverse evidence when the privilege is not waived in a personal injury suit.[10]

The current draft of the Proposed Federal Rules of Evidence has abolished the physician-patient privilege, but does contain a psychotherapist privilege.[11] The advisory note to that rule states:

> "The rules contain no provision for a general physician-patient privilege. While many states have by statute created the privilege, the exceptions which have been found necessary in order to obtain information required by the public interest or to avoid fraud are so numerous as to leave little if any basis for the privilege."[12]

In jurisdictions where the privilege ~~does exist~~, it ~~can~~ be waived by consent, voluntary disclosure by the patient of the subject matter of the confidence, or contract.[13] That in personal injury litigation it is practically inevitable that the plaintiff will waive his privilege at trial by introducing evidence as to the extent of his injuries most of the authorities agreed.[14] Numerous commentators have suggested that such waiver be accelerated to take effect at the time of the filing of the personal injury suit so as to facilitate discovery—that is, so as to ensure the defendant a proper opportunity to prepare his defense as to the medical information.[15] One author has listed discovery devices to compel such waiver in personal injury suits when the privilege is being invoked as a dilatory tactic.[16] The question of waiver in malpractice suits is the subject of the next section of this discussion.

DEFENDANT-PHYSICIAN'S ACCESS TO PLAINTIFF-PATIENT'S PRIOR AND SUBSEQUENT MEDICAL RECORDS IN MALPRACTICE ACTIONS WHERE PLAINTIFF HAS ASSERTED PHYSICIAN-PATIENT PRIVILEGE

Absent waiver of the physician-patient privilege, there is in a number of states no procedure assuring the malpractice defendant-physician pretrial discovery of plaintiff-patient's prior and subsequent medical history.[17] Without such discovery, the defendant is clearly at a great tactical disadvantage. Indeed, a recent law review comment cites a 1971 Ohio case which held that the application of the privilege in a malpractice action is an unconstitutional denial of due process and pleading.[18] The comment recognizes that although some states statutorily provide for waiver in malpractice cases, others do not.[19]

Two cases discussed in the literature illustrate the legal issues involved here. The first is a South Dakota case discussed in some detail in the law review comment mentioned above.[20] The case is a malpractice action in which the defendant-physician attempted to depose the physician who treated the plaintiff subsequent to the defendant-doctor's treatment. The issue before the court was whether the plaintiff-patient had waived the physician-patient privilege when, after filing of the suit, he had released by stipulation to defendant-doctor's counsel hospital records of the patient's subsequent care. The South Dakota Supreme Court reversed a lower court ruling and held that the privilege had not been waived. The contents of the records released not being before the court, it held that the fact of a release of hospital records whose contents were unknown to the court was insufficient to establish a waiver.[21]

A very informative article directly on point discusses the second case, an otherwise unreported case in which the Missouri Supreme Court reached a contrary result.[22] There plaintiff-patient's response to defendant-physician interrogatories were unresponsive as to prior and subsequent medical treatment. A motion to compel responsive answers was overruled. Defendant-physician then filed a motion for *subpoena duces tecum* of the prior physician; the plaintiff resisted on the grounds of privilege. The trial court sustained the motion, holding that a physician defendant to a malpractice action is entitled to discovery of medical facts by deposing both prior and subsequent treating physicians, despite the assertion of physician-patient privilege without statutory or contractual waiver. The Supreme Court declined to issue even a preliminary writ prohibiting discovery.[23]

The article in which this case is reported considers the need for such discovery and cites several factual bases upon which courts have allowed discovery either on the theory that the privilege has been waived, or despite the privilege because of the need to prepare for trial and eminent fairness.[24]

POSSIBLE REMEDIES TO PROTECT THE PATIENT AGAINST PHYSICIAN'S UNAUTHORIZED DISCLOSURE OF MEDICAL SECRETS OUTSIDE THE COURTROOM

> "Legislatures and courts have been occupied for over a century in closing the physician's mouth in the very place where the truth is badly needed (i.e., the courtroom). And yet the much more important obligation of his silence in private life has hardly been considered. In the few instances where honest patients do dread disclosure of their physical condition by a doctor, their fear is not that the truth may some day be forced out of him in a court, but that he may voluntarily spread the fact among his friends and theirs in conversation. Yet against this really dangerous possibility the statutes and the courts give almost no protection.[25]

Physician licensing statutes provide the only possibility of statutory sanctions against such unauthorized disclosure. A doctor's conduct in this respect may be found to make him unfit to hold a license, but such concept affords no remedy to the patient. A number of commentators have attempted to grapple with the challenge that Professor Chafee raises in the above quotation.

In one,[26] the author first considers possible remedies under existing theories of recovery. First he raises breach of contract. In the express or implied contract of employment between physician and patient, the author proposes the existence of an implied term of secrecy arising from the medical profession's code of ethics. This remedy, however, has received little attention, he points out, because of the difficulty in establishing contract damages in such a setting, and the even greater difficulty in gaining recovery for mental distress from a contracts remedy.[27]

The author quickly dismisses defamation, since it is subject to the defense of truth.[28]

Breach of privacy, a relatively new tort, is next considered.[29] The author points out that the tort has been divided into four classes, the first of which—disclosure of private facts—could encompass a physician's breach of secrecy.[30] However, courts have unfailingly held to a requirement of wide publicity before the disclosure is actionable; hence, concludes the author, the remedy has a limited effectiveness.[31]

The author next proposes a new tort—a fifth class under breach of privacy—called "breach of confidence." He argues that public policy reflected in privileged communications statutes, physician licensing statutes providing for loss of license upon breach of secrecy, and the medical profession's code of ethics all provide a framework for recognizing a cause of action for breach of confidence. The new tort would be a "recognition of the special characteristics of secrecy in the physician-patient privilege." It would be subject to the affirmative defense of justification, in three forms: (1) consent; (2) compulsion of the law, as in required reports of venereal disease; and (3) general public health and welfare, where some type of duty is owed to the public, e.g., a duty to protect the lives of future airline passengers when a doctor discovers a pilot's poor vision—that supersedes the duty of privacy.

The author concludes by suggesting that although the courts could extend a remedy to the patient for breach of confidence simply by acquiescing in the public policy in its favor, the new tort should be statutorily created, thus avoiding an inconsistent body of interpretive case law that would leave the physician in a constant state of uncertainty until a uniform standard was adopted. Damages should be recoverable for both pecuniary loss and mental distress. The original burden of proof should lie with the patient, but upon such proof the burden of the affirmative defense of justification should rest with the physician. "Such a statute," the author concludes, "would be the most consistent and clearly defined means of providing both recovery for the patient and a guideline for the physician."[32]

A note in the *Denver Law Review* provides a clear and comprehensive treatment of this subject, including brief summaries of recent cases on point. The article concludes that recovery grounded in malpractice because the unauthorized disclosure constitutes professional conduct falling below the prevailing professional standard of care and thus is malpractice may be the most sensible approach.[33]

The principles of this subsection would also be applicable where medical personnel disclose information concerning one patient in order to defend or prosecute another patient's malpractice action, e.g., where that information is sought to be used to establish the customary or non-customary nature of a certain course of treatment or to impeach the non-plaintiff patient's testimony if he appears as a witness. They would also be applicable to records of the plaintiff-patient insofar as he is not seeking the records himself and has not waived the protection by bringing suit (see privilege *supra*).

PATIENT'S ACCESS TO HIS OWN MEDICAL RECORDS

The literature on this issue is sparse. A comprehensive search of all periodical literature from the present through 1965 reveals only one article on point.[34] An Ohio case there cited[35] held that since hospital records are essential to proper administration, they are the property of the hospital; however, the patient has a property right in the information contained in the report.[36] The plaintiff-patient had sought a mandatory injunction compelling the defendant hospital to allow her to examine her medical records with a view toward a suit against a third party; the injunction was granted. In accord, and also discussed in the article, is a leading Oklahoma case.[37] The author there concludes from these two cases that such is the state of the law.[38]

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1. Wigmore, *Evidence* § 2380a (McNaughten rev. 1961) [hereinafter cited as Wigmore.]
2. Wigmore § 2285.
3. Wigmore § 2380a.
4. As to attempts to assert the privilege in medical malpractice action, see part (2) of this text.
5. Wigmore § 2380a.
6. *Id.* § 2380a; *see also* Baldwin, *Confidentiality Between Physician and Patient,* 22 Md.L.Rev. 181 (1962); Chafee, *Privileged Communications—Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?* 52 Yale L.J. 607 (1943); Morgan, *Suggested Remedy for Obstructions to Equal Testimony by Rules of Evidence,* 10 Ch.L.Rev. 285 (1943).
7. Wigmore § 2380a; *see also* Comment, *Waiver of Physician-Patient Privilege,* 24 Wash. & Lee L.Rev. 151, 157 (1967); *but see* Comment, *Waiver of Physician Patient Privilege,* 51 Minn. L.Rev. 575, 581 (1967).
8. Comment, *Privileged Communications—A Case-by-Case Approach,* 23 Maine L.Rev. 443 (1971).
9. Comment, *The Physician-Patient Privilege—Alternatives to the Rule as it now Exists in Oklahoma,* 24 Okla. L.Rev. 380 (1971).
10. Sawyer, *Physician-Patient Privilege—Some Reflections,* 14 Drake L.Rev. 83 (1965).
11. October 1971 draft of Proposed Federal Rules of Evidence for the United States District Courts and Magistrates, Rule 504.
12. *Id.,* Advisory Notes to Rule 504.
13. *See* Comment, *Waiver of the Physician-Patient Privilege,* 46 Chi-Kent L.Rev. 37 (1969); Stewart, *Waiver of the Physician-Patient Privilege in Personal Injury Litigation,* 2 Forum 16 (1966).
14. *But See* Comment, *Physician-Patient Privilege in Oklahoma,* 7 Tulsa L.J. 157 (1971); Comment, *Waiver of Physician-Patient Privilege,* 51 Minn. L.Rev. 575, 579 (1967).
15. *See* Comment, *Physician-Patient Privilege in Oklahoma,* 7 Tulsa L.J. 157 (1971); Comment, *Waiver of Physician-Patient Privilege,* 24 Wash. & Lee L.Rev. 151 (1967); Copple, *Physician-Patient Privilege—A Need to Revise the Arizona Law,* 6 Ariz. L.Rev. 292 (1965), *but see* Comment, *Waiver, supra* note 14.
16. Note, *Accelerated Waiver of the Physician-Patient Privilege,* 42 Wash. L.Rev. 1107 (1967); *see also* Hogan, *Waiver of Physician Patient Privilege in Personal Injury Litigation,* 52 Marq. L.Rev. 75 (1968).
17. Havener, *Malpractice Medical Discovery v. Physician-Patient Privilege—Something's Got to Give,* 35 Ins. Couns. J. 41 (1968).
18. Comment, *Patient-Physician Privilege in the Discovery Process,* 17 So. Dak. L.Rev. 188, 193. The case cited is Otto v. Miami Valley Hosp. Soc. of Dayton, Ohio, Inc., 266 N.E.2d 270, 272 (Ohio C.P. 1971).
19. *Id.* at 193.
20. *Id.* at 188, 189. The case is Hague v. Massa, 80 S.D. 319, 123 N.W.2d 131 (1963).
21. *Id.* at 189.
22. *State ex. rel. Hedrick v. Stewart,* Sup. Ct. Docket No. 27197, Sept. Session, 1964, petition for prohibition denied Dec. 14, 1964, *reported in* Havener, *supra,* at 42.
23. *Id.*
24. Havener, *supra* note 17, at 42 *cf.* the comprehensive review of the law in Urbom, *Medical Discovery in the Fifty States Plus Two,* 33 Ins. Couns. J. 41 (1968).
25. Chafee, *Privileged Communications - Is Justice Served or Obstructed by Closing the Doctor's Mouth on the Witness Stand?* supra note 6 at 617, *see also* Baldwin *supra* note 6; *but see* Comment, *Legal Protection of the Confidential Nature of the Physician-Patient Relationship,* 52 Colum. L.Rev. 383, 398 (1952).
26. Roedersheimer, *Action for Breach of Medical Secrecy Outside the Courtroom,* 36 U. Cinc. L.Rev. 103 (1966).
27. *Id.*
28. *Id.*
29. *See* Warren and Brandeis, *The Right to Privacy,* 4 Harv. L.Rev. 193 (1890).
30. *See* W. Prosser, *Law of Torts* §117 (1971).
31. For a fuller discussion of possible existing remedies, *see* Note, *Extra Judicial Truthful Disclosure of Medical Confidences - A Physician's Civil Liability,* 44 Denver L.J. 463 (1967).
32. Roedersheimer, *supra* note 27.
33. Note, *Extra Judicial Truthful Disclosure, supra* note 32; *see also* 79 Harv. L.Rev. 1723 (1966); 11 Vill. L.Rev. 662 (1966).
34. Fleisher, *Ownership of Hospital Records and Roentgenograms,* 4 Ill. Continuing Legal Ed. 73 (1966).
35. *Wallace v. University Hospitals of Cleveland,* 82 Ohio Law Abstract 224, 164 N.E.2d 917, 918 (1959), *cited in* Fleisher, *supra* note 35.
36. As a practical matter this property right constitutes a right to inspect and copy.
37. *Pyramid Life Ins. Co. v. Masonic Hospital Ass'n,* 191 F.Supp. 51 (W.D. Okla 1961), *cited in* Fleisher, *supra* note 35.
38. Fleisher, *supra* note 35, at 75, 77.

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Sagal, *Physician's Medical Report*, 8 Trial 59 (1972)

Sawyer, *Physician Patient Privilege—Some Reflections*, 14 Drake L.R. 83 (1965)

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Urbom, *Medical Discovery in the Fifty States Plus Two*, 33 Ins. Couns. J. 41 (1968)

Warren and Brandeis, *The Right to Privacy*, 4 Harv. L.Rev. 193 (1890)

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Note, *Accelerated Waiver of the Physician Patient Privilege*, 42 Wash. L.R. 1107 (1967)

Comment, *Doctor's Duty of Secrecy*, 115 D. Foulkes L.J. 673 (1965)

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Comment, *Legal Protection of the Confidential Nature of the Physician-Patient Relationship*, 52 Colum. L.Rev. 383 (1952)

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Physician-Patient Privilege in Oklahoma, 7 Tulsa L.J. 157 (1971)

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Comment, *Waiver of Physician-Patient Privilege*, 51 Minn. L.Rev. 575 (1967)

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————, *The Quest for Hospital Records*, 45 Infirmiere 100 (Oct. 1971)

Dornette, *Medical Records*, 8 Clin. Anesth. 285 (1972)

————, *The Physician-Patient Relationship*, 8 Clin. Anesth. 213 (1972)

Hagman, *The Non-litigant Patient's Right to Medical Records—Medicine v. Law*, 14 J. Forensic Sci. 352 (July 1969)

Ederma, *Confidentiality of Medical Records and Invasion of Privacy*, 11 J. Occup. Med. 200 (April 1969)

Horty, *Court's Need Can Impose Limits on Physician-Patient Privilege*, 113 Mod. Hosp. 54 (August 1969)

————, *Medical Records Aren't Fishing Grounds*, 116 Mod. Hosp. 68 (March 1971)

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Physician and Hospital Record Retention and Inspection, 68 Wisc. Med. J. 38 (Jan. 1969)

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Suggestions for Further Study

The question pertinent to malpractice actions about which the law is largely silent or ambiguous is the issue of the patient's right to see his own medical record, particularly without first commencing litigation. The nine state statutes specifically relating to the issue are permissive, and assert the patient's right without placing restrictions on it.

We conclude, therefore, that the most serious impediment to obtaining access to hospital records can be the policies of individual hospitals against disclosure. Further investigation of these informal practices would be invaluable.

In the absence of a statute, decision, or regulation specifically granting access, a hospital policy against disclosure can be the major obstacle confronting a person trying to inspect his hospital records.

Automated central record computers are a possible source of medical information. These ought to be investigated with respect to access. Who supplies information and who may get it? What regulation is there of this function? (See, for an introduction to the area, Springer, *Automated Medical Records and the Law* (1971).

No attempt has been made to study the doctor's ethical duties respecting disclosure nor the problem of in-house and scientific or disciplinary use of a patient's records. Also beyond the scope of the current study was law enforcement, Workmen's Compensation, various public welfare and Social Security programs, and public employment.

State-by-State Study

This study summarizes the law of each state under five headings: physician-patient privilege, public record acts, medical lien acts, required reports, special access laws. Each heading may have three sub-headings: Statute, case-law, regulations. Where a heading or sub-heading is omitted in the summary of any state, that state's law is silent on that heading or sub-heading.

ALABAMA

Physician-Patient Privilege

Statute: Alabama has a statutory psychologist-client privilege which is placed on the same basis as the attorney-client privilege.[1]

Required Reports

Statute: Physicians are required to file reports of cases of veneral disease.[2] By a separate statute these reports are made confidential.[3]

Special Access Laws

Regulations: The questions of confidentiality and disclosure of medical records in Alabama is addressed through administrative regulations established by the Alabama State Board of Health, which provides that patients' records are confidential. Access to the records is determined by the hospital governing board.

Inspectors for licensure or surveyors for membership in professional organizations have a limited right to review records.[4] The regulations provide for monthly review and analysis of the clinical experience of the medical staff, using the patients' medical records as the basis for such review.[5] Title to the records is vested in the hospital, and control rests with the hospital administrator.[6] The regulation on storage and safety of records states that records are to be handled in such a manner as to safeguard them from unauthorized use. *Mental patients:* The State Mental Health Board has the power to set standards for the transfer of patients and their records. ALA. CODE tit. 22 §320(11) (Supp. 1969). The board of trustees of hospitals for the insane has access to the books and records of the hospital at any time. ALA. CODE tit. 45 § 203 (1958).

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[1] ALA. CODE tit. 46, § 297(36) (Supp. 1969)
[2] ALA. CODE tit. 22, § 262, 267 (1958)
[3] ALA. CODE tit. 22, § 269 (1958)
[4] Alabama State Board of Health, Rules, Regulations and Standards: § 701.8 (1970)
[5] *Id.* § 502.1(4)
[6] *Id.* § 701.4
[7] *Id.* § 701.2

ALASKA

Physician—Patient Privilege

Statute: Physician or surgeon may not, against the objection of his patient, be examined in a civil action or proceeding as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient.[1] This privilege does not apply in cases concerning child abuse.[2]

Case Law: Plaintiffs in personal injury actions waive privilege by commencement of the action to the extent that attending physicians may be required to testify on pretrial deposition with respect to injuries sued upon.[3]

Public Record Acts

Statute: Statute granting right of public inspection lists exception for medical and related public health records.[4]

Special Access Laws

Statute: Records of mental patients may only be disclosed as (1) the individual consents, or (2) as a court directs if necessary for the conduct of proceedings before it and non-disclosure would be contrary to the public interest.[5]

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[1] ALAS. R.CIV. P.43(h)4 (Supp. 1968)
[2] ALAS. R.CIV. P.43(h)8 (Supp. 1968)
[3] Mathis v. Hilderbrand, 416 P.2d 8, 10 (Alas. 1966)
[4] ALASKA STAT. § 09.25.120(3) (1962)
[5] ALASKA STAT. § 47.30.260 (1962)

ARIZONA

Physician-Patient Privilege

Statute: In a civil action, a physician or surgeon may not, without the consent of his patient, be examined as to communications or knowledge obtained in examination of the patient.[1] Privilege is waived if the person voluntarily testifies as to such communications.[2]

In criminal actions a physician may not be examined as to any information acquired in attending the patient which was necessary to enable him to treat the patient.[3]

Unprofessional conduct includes willful betrayal of a professional secret or willful violation of a privileged communicational except as required by law.[4]

Case Law: Privilege as an objection applies to questions put to plaintiff at deposition.[5]

Public Record Acts

Statute: Information in vital records is not to be disclosed.[6]

Special Access Laws

Regulations: State regulation regarding clinical records is silent as to accessibility.

Other: According to Arizona Hospital Association "Consent Manual" hospital records are the property of the hospital and may only be released to various classes of "interested persons" including patient's attorney when authorized in writing, patient's insurance company, but only directly to patient upon the consent of the administrator or attending physician. When attorney employed by the patient requests information "his reason for such request should first be determined." Although not a legal necessity, the hospital may, as a matter of policy, call for the consent of attending physicians.[8]

June 12, 1972

Mr. Peter B. Stein
Task Force on Medical Malpractice
Georgetown University Law Center
Washington, D.C. 20001

Dear Mr. Stein:

This is in response to your letter of June 6, 1972 requesting information regarding statutes, regulations and practices relating to access to hospital and medical records in Arizona.

Enclosed is a copy of Article 7, Chapter 13, Title 12, Arizona Revised Statutes. These Sections are the only provisions of Arizona law relating to obtaining records which are specifically applicable to hospital records. Enclosed also is a copy of Arizona State Department of Health Regulations for the Licensure of Hospitals which contains Regulation 4-2-4.1 (mentioned in your letter). As may be seen, this regulation does not provide any very helpful guidance regarding access to these records. I am also enclosing a copy of Chapter 19 of the Arizona Hospital Association "Consent Manual". This material was prepared in 1967 and, therefore, does not necessarily reflect the provisions of the hospital records statutes mentioned above. However, I am advised that from the pragmatic standpoint the material in Chapter 19 is pretty closely adhered to by hospitals in Arizona.

With respect to the three questions in your letter, it would appear that access to hospital and medical records may be had (1) by this Department as the licensing agency without consent; (2) by a physician on the assurance that he is the physician of the patient whose records are sought; and (3) by other persons with the consent of the patient. If the custodian of the record is reluctant to provide the record upon request, the applicant may, of course, be forced to obtain a subpoena. Question 2 is covered above. In answer to question 3, a person giving consent must be competent and, if not the patient, must be a legal guardian or otherwise authorized to give consent to access. [. . . .]

Very truly yours,

William J. White, Director
Management Advisory Services
Division

WJW:me
Enclosures 3

ARKANSAS

Physician-Patient Privilege

Statute: Arkansas has a privileged communications statute which applies to physicians, surgeons and trained nurses, making them incompetent witnesses as to information acquired from the patient while attending him in a professional character and which was necessary to treat him.[1] There is a separate statutory privilege for communications between psychologist and client, which privilege is placed on the same basis as that between attorney and client.[2]

Case Law: While it was apparently assumed that this privilege applies in criminal as well as civil actions, the statute was only recently construed as applicable to criminal proceedings.[3] *Waiver of privilege:* Arkansas has rejected the view taken by some states that the filing and maintenance of an action to recover for physical injuries in itself constitutes a waiver of the physician-patient privilege so as to require testimony of attending physicians on pretrial deposition or disclosure of medical records and information. Bower v. Murphy, 247 Ark. 238, 444 S.W.2d 883 (1969). On this issue the court relied on earlier Arkansas cases, stating that discovery and pretrial statutes were not in such conflict with those decisions as to require a departure from the rules therein stated. See Maryland Casualty v. Maloney, 119 Ark. 434, 178 S.W. 387 (1915) and American Republic Life Ins. Co. v. Edenfield, 228 Ark. 93, 306 S.W.2d. 321 (1957). However, the court went on to hold that the trial court may require the plaintiff-patient to state whether or not he intends to rely on or waive the physician-patient privilege. If the privilege will be waived and medical evidence offered at trial, such evidence may be discovered by the defendant. *Records available for research:* An Arkansas statute provides that records of certain medical societies and hospital committees are available for medical research only and are strictly confidential. ARK. STAT. ANN. 82-357, 358 (Supp. 1971).

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[1] ARIZ. REV. STAT. § 12-2235 (1956).

[2] ARIZ. REV. STAT. § 12-2236 (1956).

[3] ARIZ. REV. STAT. § 13-1802 (Supp. 1971).

[4] ARIZ. REV. STAT. § 32-1404(10)(b) (Supp. 1971).

[5] Patania v. Silverstone, 3 Ariz. App. 424, 415 P.2d 139, 144 (1966).

[6] ARIZ. REV. STAT. § 36-339 (Supp. 1971).

[7] Arizona Department of Health, Rules and Regulations for the Licensing of Hospitals, Reg. 4-2-4.1.

[8] Arizona Hosp. Ass'n. Consent Manual, ch. 19 (1969).

Public Record Acts

Statute: Medical records are specifically exempted from the Freedom of Information Act.[4]

Special Access Laws

Regulations: The rules and regulations for hospitals in Arkansas make medical records confidential material. Only personnel authorized by the hospital administrator have access to the records, with the exception of personnel of the State Board of Health, to whom the records are available.[5] Although the records are confidential, the written consent of the patient or his legal guardian is authority for disclosure of medical information.[6] Medical records are to be removed from the hospital environment only upon the issuance of a subpoena by a court of competent jurisdiction.[7]

CALIFORNIA

Physician-Patient Privilege

Statute: California's comprehensive statute[1] protects confidential communications between authorized, or reasonably believed by patient to be authorized, physician[2] and a person who consults him for diagnosis or treatment for a physical, mental or emotional condition.[3] The privilege is held by the patient, his guardian or personal representative if the patient is dead.[4] The privilege may be waived by the patient.[5] There are statutory exceptions for (1) where the patient or a party claiming through him puts his condition in issue[6], (2) if the physician's services were sought in an effort to commit a crime or tort,[7] (3) in criminal proceedings,[8] (4) in a proceeding to recover damages from criminal conduct,[9] (5) where all parties are claiming through a deceased patient,[10] (6) where at issue is a question of breach of duty arising out of physician-patient relationship,[11] (7) in an action testing the validity of a will,[12] (8) in a commitment proceeding,[13] (9) or one to establish competence,[14] (10) as to information required to be reported,[15] (11) in an administrative proceeding to terminate a right or license.[16] Psychotherapist-patient communications are also privileged,[17] with a similar range of exceptions,[18] except in criminal proceedings unless the psychotherapist is court appointed.[19]

Eavesdropping on a conversation between, among others, a person and his physician is a felony.[20]

Willful betrayal of a professional secret is unprofessional conduct, but the privilege does not apply to physician licensing proceedings.[21]

Case Law: Section relating to confidential communication between physician and patient must be liberally construed in favor of patient.[22]

Requiring doctor and hospital in malpractice action to disclose names and addresses of patients who had received same type of tests was violation of privilege, especially with respect to two patients who had developed complications from such testing.[23]

Where the plaintiff tendered issue of her mental and emotional condition by seeking recovery of expenses for psychiatric care, there existed no testimonial privilege which would permit plaintiff's psychiatrist to refuse to answer questions at the taking of his deposition.[24]

Public Records Acts

Statute: Medical files, the disclosure of which would constitute an unwarranted invasion of personal privacy are exempted from the right of public inspection[25].

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[1] ARK. STAT. ANN. § 28-607 (1962)
[2] ARK. STAT. ANN. § 72-1516 (1957)
[3] Ragsdale v. State, 245 Ark. 299, 432 S.W.2d. 11 (1968)
[4] ARK. STAT. ANN. § 12-2804 (1968)
[5] Arkansas Department of Health, Rules and Regulations for Hospitals and Related Institutions (1969)
[6] Id., §I(D).
[7] Id., §I(E).

Required Reports

Statutes: Physician-patient privilege statute includes exception for required reports.[26] These include injuries due to violence,[27] non-accidental injuries to children,[28] and communicable diseases.[29] Venereal disease reports to local health departments are confidential and health officers, receiving a subpoena for such a record, may assert a privilege.[30]

Special Access Laws

Statute: Medical records are to be made available to a patient's attorney upon written authorization prior to filing of any action. Failure to make records available within five days may subject the person having custody or control of the records of liability for legal expenses, including attorney's fees, incurred in any proceeding to enforce the section.[31]

This statute does not apply[32] to the statute making records of mental patients confidential.[33]

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[1] CAL. EVID. CODE §§ 990-1007 (West 1966).
[2] CAL. EVID. CODE § 990 (West 1966).
[3] CAL. EVID. CODE §991 (West 1966).
[4] CAL. EVID. CODE § 993 (West 1966).
[5] CAL. EVID. CODE §994 (West 1966).
[6] CAL. EVID. CODE §996 (West 1966).
[7] CAL. EVID. CODE § 997 (West 1966).
[8] CAL. EVID. CODE §998 (West 1966).
[9] CAL. EVID. CODE § 999 (West 1966).
[10] CAL. EVID. CODE § 1000 (West 1966).
[11] CAL. EVID. CODE § 1001 (West 1966).
[12] CAL. EVID. CODE §1002 (West 1966).
[13] CAL. EVID. CODE § 1004 (West 1966).
[14] CAL. EVID. CODE §1005 (West 1966).
[15] CAL. EVID. CODE §1006 (West 1966).
[16] CAL. EVID. CODE §1007 (West 1966).
[17] CAL. EVID. CODE §§ 1010-21 (West 1966).
[18] CAL. EVID. CODE §§ 1016-21 (West 1966).
[19] CAL. EVID. CODE § 1017 (West 1966).
[20] CAL. EVID. CODE § 636 (West 1966).
[21] CAL. BUS. & PROF. CODE § 2379 (West Supp. 1971).
[22] Carlton v. Superior Court, 67 Cal. Rptr. 568, 261 Cal. App.2d 282, *cert. denied*, 68 Cal. Rptr. 469, 261 Cal. App.2d 282 (1968). Newell v. Newell, 146 Cal. App.2d 166, 303 P.2d 839 (1956).
[23] Marcus v. Superior Court, 95 Cal. Rptr. 545, 18 Cal. App.2d 22 (1971).
[24] Hall v. Superior Court, 97 Cal. Rptr. 879 (1971).
[25] CAL. GOV'T CODE § 6254(c) (West Supp. 1971).
[26] CAL. EVID. CODE § 1006 (West 1966).
[27] CAL. PENAL CODE § 11160 (West Supp. 1972).
[28] CAL. PENAL CODE §11161.5 (West Supp. 1972).
[29] CAL. HEALTH & SAFETY CODE § 3125 (West 1970).
[30] CAL. EVID. CODE § 1040 (West 1966); 53 CAL. OP. ATT'Y GEN. 10 (1970).
[31] CAL. EVID. CODE § 1158 (West Supp. 1972).
[32] 53 CAL. OP. ATT'Y GEN. 151 (1970).
[33] CAL. WELF. & INST'NS CODE § 5328 (West Supp. 1972).

COLORADO

Physician-Patient Privilege

Statute: Physicians and surgeons may not be examined without patient's consent as to any information acquired in attending patient necessary to enable him to prescribe or act for patient, but there is no privilege where physician is used by or on behalf of a patient.[1]

Privilege applies to psychologists, their secretaries and persons participating in group therapy sessions.[2]

Privilege is waived if party offers himself or physician as a witness.

Privilege does not apply to physicians or psychiatrists directed by the court to examine criminal defendants; but any information acquired, including confessions and admissions, is admissable only on the issue of insanity.[4]

Case Law: Once plaintiff raised issue of his physical condition by introducing testimony of two doctors as to the seriousness of his injury, he waived physician-patient privilege as to all physicians consulted.[5]

Public Records Acts

Statute: Right of inspection of public records is denied as to medical, psychological, sociological and scholastic achievement data on individual persons.[6]

Medical Lien Acts

Statute: Person against whom lien is asserted is permitted to examine the financial records of the hospital in reference to the services furnished for which the hospital asserts a lien.[7]

Required Reports

Statutes: Physicians must report suspected cases of child abuse[8] to which privilege does not apply.[9] Reports of venereal disease are not required to include names except, where necessary, to health officer, spouse, fiance(e) or parent.[10] Cases of tuberculosis are also required to be reported.[11]

Special Access Laws

Regulations: State regulations pertaining to hospital records are silent as to release of information; but they do state that legal counsel should be obtained prior to disposition of medical records.[12]

Other: Health Department Legal Counsel has stated "Patient's consent plus release from physician involved would probably gain access to any medical record as a matter of practical application.[13]

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[1] COLO. REV. STAT. ANN. § 154-1-7(5) (1963).
[2] COLO. REV. STAT. ANN. § 154-1-7(8) (Supp. 1967).
[3] COLO. REV. STAT. ANN. § 154-1-8 (1963).

[4] COLO. REV. STAT. ANN. §39-8-2(3)(b) (1963).

[5] Kelley v. Holmes, 28 Colo. App. 79, 470 P.2d 590, 592 (1970).

[6] COLO. REV. STAT. ANN. § 113-2-4(3)(b) (Supp. 1969).

[7] COLO. REV. STAT. ANN. § 86-8-4 (Supp. 1967).

[8] COLO. REV. STAT. ANN. § 22-10-2 (Supp. 1969).

[9] COLO. REV. STAT. ANN. § 22-10-5 (Supp. 1969).

[10] COLO. REV. STAT. ANN. § 66-9-2 (Supp. 1967).

[11] COLO. REV. STAT. ANN. § 66-12-2 (Supp. 1967).

[12] Colorado Dept. of Health, "Hospital and Health Facility Standards," ch. IV, § 4.2.

[13] Letter from David F. Foster, Legal Counsel, Colorado Department of Health to the Task Force, June 8, 1972.

CONNECTICUT

Physician-Patient Privilege

Statute: There is no physician-patient privilege in Connecticut. However, such a privilege does exist in the special case of persons who consult psychotherapists. In 1969, the legislature enacted a psychologist-patient privilege[1]. In the same year the existing provisions dealing with the psychiatrist-patient privilege were rewritten[2]. The law now forbids disclosure of (defined) communications between psychiatrist and patient, where the patient is identifiable, to any person, corporation or government agency without the consent of the patient or his authorized representative. However, consent of the patient is not required for disclosure of records in the following situations:

1. where disclosure is to other persons engaged in the treatment of the patient.
2. when the psychiatrist determines that there is substantial risk of imminent physical injury by the patient to himself or to others or when a psychiatrist finds disclosure necessary for the purpose of placing the patient in a mental health facility.
3. where an individual or agency is attempting to collect fees for psychiatric services (only name, address and fees may be disclosed).
4. where records have been made by a psychiatrist in the course of a court-ordered psychiatric examination, subject to certain restrictions.
5. where, in a civil proceeding, the patient has introduced his mental condition as an element of his claim or defense and the court feels that disclosure is necessary in the interests of justice.

The statutes dealing with the psychiatrist-patient privilege also provide for access to records by persons engaged in research. Any person aggrieved by a violation of these provisions may petition the proper courts for appropriate relief, including injunctions, and may maintain a civil cause of action for damages.

Public Record Acts

Statute: Medical records are specifically exempted from the statutory provisions granting access to public records to state residents.[3] Information received by the State Department of Health through filed reports, etc., shall not be disclosed publicly so as to identify individuals or institutions except in a licensure proceeding.[4]

Required Reports

Statutes: Physicians must file reports of cases of occupational disease to the State Department of Health.[5] Physicians must also file reports of drug dependent persons, which reports will be kept confidential.[6]

Special Access Laws

Statutes: Connecticut is one of the few states whose statutes expressly give the patient, his doctor, or his authorized representative the right to examine the hospital record under certain conditions.[7] The statute applies to public and private hospitals, and requires the hospital, upon demand of the patient, after discharge, to permit the patient, his physician or his authorized attorney to examine the hospital record, including the history, bedside notes, charts, pictures, and plates. Copies may be made. A subsequent statute sets forth the procedure to be followed where the right to inspect the records is denied.[8]

Case Law: A 1940 case held that in a personal injury action, defendant's motion that the court require the plaintiff to authorize the defendant's physician to inspect certain records was required to be denied, where it was not alleged and did not appear that the records sought to be examined were in the knowledge, power or possession of the plaintiff. It was not clear whether this holding has any meaning in light of the statute's discussed in this section.[9]

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[1] CONN. GEN. STAT. ANN. § 52-146c (Supp. 1972).

[2] CONN. GEN. STAT. ANN. § 52-146d to j (Supp. 1972).

[3] CONN. GEN. STAT. ANN. § 1-19 (Supp. 1972).

[4] CONN. GEN. STAT. ANN. § 19-39 (1969).

[5] CONN. GEN. STAT. ANN. § 19-48 (1969).

[6] CONN. GEN. STAT. ANN. § 19-48a (1969).

[7] CONN. GEN. STAT. ANN. § 4-104 (1969).

[8] CONN. GEN. STAT. ANN. § 4-105 (1969).

[9] Byscynski v. McCarthy Freight System, 9 Conn. Supp. 44 (1940).

DELAWARE

Physician-Patient Privilege

Statute: In 1962, Delaware enacted a statutory psyschologist-client privilege, which is the same as the attorney-client privilege.[1] Although no statutory physician-patient privilege is to be found in the Delaware Code, miscellaneous statutes refer to a general privilege of confidentiality.[2]

Medical Lien Acts

Statute: Delaware's hospital lien law specifically provides that a hospital seeking to assert a lien must make the hospital records available for examination to the person who is legally liable or against whom a claim shall be asserted for compensation for injuries.[3]

Special Access Laws

Regulations: Delaware has adopted as a regulation the standards of the Joint Commission on Accreditation of Hospitals. Standard III relating to the medical records department requires the written consent of the patient in order to release medical information to persons not generally authorized to receive it. In the absence of such consent, records may be removed from the hospital only by court order or subpoena. The requirements for confidential records vary in different programs of the Health Department.[4]

Discovery: Cases construing Delaware's discovery rules (generally the same as the Federal Rules of Civil Procedure) have held that where, in a personal injury action, injuries alleged are complex, and involve the testimony of several medical experts of different specialties, and where the taking of depositions as a prerequisite to the production of documents would involve unnecessary burdens to time and expense, a showing of good cause sufficient to allow hospital reports to be subject to discovery can generally be found. Thompson v. E. R. Trucking Co., Del. Super. 1968, 249 A.2d 436 (1968), citing Ariff v. Powers, 479 Civil Action, Del. Super. 1966.

In cases involving medical malpractice which rise to the level of criminal negligence, including assault and battery and manslaughter, the State Department of Justice has broad powers of discovery and inspection through subpoena powers. Letter from Kent Walker, State Solicitor, to the Task Force; June 9, 1972.

DISTRICT OF COLUMBIA

Physician-Patient Privilege

Statute: D.C. has a privileged communications statute which applies to physicians and surgeons and prohibits disclosure without the consent of the patient or his legal representative of confidential information acquired in attending the patient and which was necessary to enable him to act in that capacity, whether the information was obtained from the patient, his family or persons in charge of him.[1] The privilege, however, does not apply to—

1. evidence in criminal cases where the accused is charged with causing the death of or injuring a person, and disclosure is necessary in the interests of public justice
2. evidence relating to the mental competency of an accused in criminal trials where the accused or the court raises the defense of insanity or in the pretrial or post-trial proceedings involving a criminal case where a question arises concerning the mental condition of the accused
3. evidence relating to the mental competency of a child in a proceeding before the Family Division of the Superior Court.

A separate statute extends the privilege to psychologists.[2]

Case Law: In a 1967 case the United States Court of Appeals for the District of Columbia held that the physician-patient privilege does not operate to relieve a hospital or doctor from the duty to reveal medical records to the next of kin of a deceased patient.[3] The statute applies to information in hospital records concerning diagnosis or treatment.[4]

Medical Lien Acts

Statute: Pertains only to inspection of fiscal records.[5]

Required Reports

Statute: Required reports of cases of cancer and malignant growths are made confidential and are not open to public inspection.[6] Only upon court order may the identify of the patient be divulged only on the written authorization of the director of public health.

Special Access Laws

Regulations: In D.C. anyone may obtain access to hospital and medical records who has a legitimate interest in them, upon application accompanied by a written authorization for release by the patient or former patient, if an adult; or if a minor, by the parent or guardian. Hospital and clinical medical records are the property of the institution. Except in rare circumstances, a patient has access to his medical records, and if access were refused to the patient, it would be granted to his attorney.[7]

Mental patients: Records of mental patients are to be made available, upon the person's written authorization, to his attorney or personal physician. The records are to be preserved by the administrator until the patient has been discharged from the hospital. D.C. CODE § 21-562 (1967). A 1969 case held that the fact that the hospital to which a mentally ill person has been civilly committed may not, under this statute, disclose hospital records to outside parties without the patient's consent does not imply that it is forbidden to introduce them in court where they are relevant to the patient's contentions on habeas corpus. Covington v. Harris, 419 F.2d 617 (D.C. Cir. 1969).

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[1] DEL. CODE. ANN. tit. 24, § 3534 (Supp. 1970).

[2] *See, e.g.,* DEL. CODE. ANN. tit. 24, § 1741 (Supp. 1970).

[3] 3DEL. CODE ANN. **tit. 25**, § 4306 (1953).

[4] Letter from Harry F. Camper, Director, Bureau of Comprehensive Health Planning and Research, Division of Public Health to the Task Force, June 14, 1972.

In a 1971 case, the court said in a footnote, relying on § 21-562, that when a patient is committed to a public mental hospital for treatment, the hospital has a statutory obligation to make its records available to his counsel and to his personal physician, and justice demands no less for a patient who is committed to the hospital for observation in preparation for criminal trial. United States v. Schappel, 445 F.2d 716 (D.C. Cir. 1971). See also Thornton v. Corcoran, 407 F.2d 695, 702 f. (D.C. Cir. 1969) and Washington v. United States, 390 F.2d 444, 447 (D.C. Cir. 1967).

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[1] D.C. CODE ANN. §14-307 (Supp. V 1972).

[2] D.C. CODE ANN. §2-496 (Supp. V 1972).

[3] Emmett v. Eastern Dispensary and Casualty Hospital, 396 F.2d 931 (D.C. Cir 1967).

[4] Ferguson v. Quaker City Life, 129 A.2d 189 (D.C. Mun. App. 1957), *see also*, Sher v. De Haven, 199 F.2d 777 (D.C. Cir, 1952) *cert. denied.* 345 U.S. 936 (1953).

[5] D.C. CODE ANN. §38-304 (1967).

[6] D.C. CODE §6-1302 (1967).

[7] Letter from Edward Harrigan, Legal Assistant, Department of Human Resources to the Task Force, June 12, 1972.

FLORIDA

Physician-Patient Privilege

Statute: There is no general physician-patient privilege in Florida. There is, however, a statutory psychiatrist-patient privilege which applies in civil and criminal cases.[1] However, the privilege does not apply if the patient introduces his mental condition as an element of his claim or defense. There are also certain limited statutory provisions for waiver of the privilege during court-ordered psychiatric examinations. The same privilege is applied by a separate statue to communications between psychologist and client.[2]

Public Record Acts

Statute: Florida's act making public records open to examination by citizens does not specifically exempt medical and hospital records.[3] It would appear that attorney general opinions have established some specific exemptions in this area.[4]

Regulations: With reference to state institutions, state hospitals, etc., unless the specific statute governing the institution or hospital provides for confidentiality of records, this would fall under Chapter 119 (see II-A, *supra*). Nevertheless, even in these instances, the medical personnel and administrators of the institutions follow the 'common law' practice of maintaining confidentiality and considering such records to be the property of the hospitals.[5]

Special Access Laws

Statute: It is expressly provided by statute that a doctor making a physical or mental examination or treating a person, must, upon the request of the patient, his guardian, curator, or personal representative, furnish copies of all reports made of such examination or treatment.[6] Reports are not to be furnished to anyone else without the patient's consent, with the exception of a person or corporation who, with the patient's consent, procured or furnished the examination or where a compulsory physical examination is made pursuant to the Florida Rules of Civil Procedure.

Regulations: In Florida, medical records are considered confidential information between doctor and patient, and access to hospital and medical records is allowed only with the express permission of the patient himself or of the doctor in charge of the patient.[7] A patient's records may be released upon his signature on a waiver and release form, and submission by the party to whom the records are to be released of such form.[8] Records are considered to be the private property of the hospital.

Research: Statutes permit the release of medical information to certain study groups and state that the identity of the person studied shall remain confidential. FLA. STAT. ANN. §§ 405.01 *et seq.* (Supp. 1972). Mr. Eisenberg in letter cited above concludes: "... there exist elements of conflict in the practice and application of laws relating to medical records in the State of Florida."

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[1] FLA. STAT. ANN. § 90.542 (Supp. 1972).

[2] FLA. STAT. ANN. § 490.32 (Supp. 1972).

[3] FLA. STAT. ANN. § 119.01 (1960).

[4] 1941 FLA. OP. ATT'Y GEN. 126; 1958 FLA. OP. ATT'Y GEN. 058-127. Cited from the statutory material in FLA. STAT. ANN. § 119.01 (1960)

[5] Letter from Robert M. Eisenberg, General Council, Department of Health and Rehabilitative Services, to the Task Force, June 20, 1972.

[6] FLA. STAT. ANN. § 458.16 (Supp. 1972).

[7] Letter from George Palmer, M.D. To Task Force, June 12, 1972.

[8] Letter from Robert M. Eisenberg; see note 5, *supra*.

GEORGIA

Physician-Patient Privilege

Statute: Georgia's confidential communications statute covers only psychiatrists.[1] A separate statute makes communications between psychologists and clients privileged.[2]

Case Law: There is no confidential relationship between doctor and patient in Georgia.[3]

Psychiatrist-patient privilege is waived by calling doctor as witness to testify as to one's mental condition.[4]

Public Record Acts

Statute: Medical records are exempt from public inspection. The identity of persons furnishing medical information incorporated in public health reports of the Department of Public Health are specifically protected from disclosure.[5]

The clinical record of a patient in a state hospital declared by statute not to be a public record.[6]

Required Reports

Statute: Physicians and hospitals are required to report cases of venereal disease[8] and suspected cases of child abuse.[9]

Special Access Laws

Statute: The clinical records of patients in state hospitals may not be released except to physicians, attorneys and government agencies as designated by the patient, or in response to a subpoena (except matters privileged under §38-418 (5).[10]

Regulations: Code §38-418(5) (privilege for psychiatrists) has resulted in a practice of not releasing any medical records without the patient's authorization.

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[1] GA. CODE ANN. § 38-418(5)(Supp. 1971).
[2] GA. CODE ANN. § 84-3118 (1970).
[3] Collins v. Howard, 156 F. Supp. 322, 324 (S.D. Ga. 1957).
[4] Fields v. State, 221 Ga. 307. 144 S.E.2d 339,342 (1965).
[5] GA. CODE ANN. § 40-2703 (1971).
[6] GA. CODE ANN. § 88-502.10 (a) (Supp. 1971).
[7] GA. CODE ANN. § 67-2207 to 67-2213 (1967).
[8] GA. CODE ANN. § 88-1602 (1971).
[9] GA. CODE ANN. § 74-111 (Supp. 1971).
[10] GA. CODE ANN. § 88-502.10 (1971).

HAWAII

Physician–Patient Privilege

Statute: A Physician may not divulge information acquired in attending a patient in any civil action, unless the sanity of the patient is the matter in dispute. The privilege is waived in personal injury suits or where the party offers himself or physician as a witness to testify as to his physical condition.[1]

Required Reports

Statute: Cases of injuries suspected to be caused by violence are required to be reported,[2] as well as cases of child abuse[3] and communicable diseases.[4] Identity of latter patients are not to be made public.[5]

Special Access Laws

Statute: Information from court-ordered physical examination in personal injury action may be divulged without the consent of the person examined.[6]

Records of patients in mental facilities are not to be disclosed except as the patient consents or as the court may order.[7]

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[1] HAWAII REV. STAT. § 621-20 (1968).
[2] HAWAII REV. STAT. § 453-14 (1968).
[3] HAWAII REV. STAT. § 350 (1968).
[4] HAWAII REV. STAT. § 325-4 (1968).
[5] HAWAII REV. STAT. § 325-4 (1968).
[6] HAWAII REV. STAT. § 625-12 (1968).
[7] HAWAII REV. STAT. § 334-5 (1968).

IDAHO

Physician–Patient Privilege

Statute: A physician cannot, without the consent of his patient, be examined in a civil action as to any information acquired in attending patient except (1) in cases of child abuse, (2) after patient's death in any action involving the validity of his will, (3) in personal injury actions, and, (4) in an action by a beneficiary to recover on life insurance policy.[1]

In a criminal trial where the defendant raises defense of mental illness, statements made to an examining psychiatrist are admissable upon the issue of his mental condition whether or not it would otherwsie be deemed a privileged communication.[2]

License to practice medicine is subject to revocation for willful betrayal of professional secret or willful violation of privileged communication except as required by law.[3]

Case Law: Privilege does not apply to criminal cases.[4]

Privilege may be waived by personal representative or heirs of decedent.[5]

Required Reports

Statute: Physicians and hospitals are required to report cases of child abuse.[6]

Special Access Laws

Statute: Records of patients hospitalized for mental illness are not to be disclosed except (1) by the patient's consent or (2) as a court may direct.[7]

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[1] IDAHO CODE § 9-203 (4) (Supp. 1971).
[2] IDAHO CODE § 18-409 (Supp. 1971).
[3] IDAHO CODE § 54-1810 (h)(2)(Supp. 1971).
[4] State v. Coburn, 82 Idaho, 437, 354 P.2d 751, 756-7 (1960).
[5] In re Groan's Estate, 83 Idaho 568, 366 P.2d 831,836 (1961).
[6] IDAHO CODE § 16-1641 (Supp. 1971).
[7] IDAHO CODE § 66-348 (a) (Supp. 1971).

ILLINOIS

Physician-Patient Privilege

Statute: Illinois recognizes the physician-patient privilege,[1] which prohibits any physician from disclosing any information acquired in attending a patient in a professional relationship which is necessary for treatment. However, the privilege does not apply: (1) in homicide cases where the disclosure relates directly to the fact or immediate circumstances of the homicide; (2) in malpractice actions against a physician; (3) with the consent of the patient or, if deceased or disabled, his personal representative or the beneficiary of an insurance policy; (4) in all civil suits brought by or against a patient or his personal representative where the patient's physical or mental condition is an issue; (5) in a will contest; (6) in any criminal action where abortion, murder by abortion, or attempted abortion is a charge; (7) in actions arising from a required child abuse report.

A psychiatrist-patient privilege is also recognized in Illinois.[2] It provides that a patient or his authorized representative and a psychiatrist or his authorized representative have the privilege to refuse to disclose and to prevent a witness from disclosing communications relating to diagnosis or treatment of the patient's mental condition between the patient and psychiatrist or members of the patient's family and the psychiatrist. The privilege does not apply, however: (1) in hospitalization proceedings initiated by the psychiatrist; (2) if the patient, having been warned that communications would not be privileged, makes communications to a psychiatrist during a court ordered psychiatric examination; (3) in a civil or administrative proceeding in which the patient or his personal representative introduced his mental condition as an element of his claim or defense, except that the privilege may be asserted in any divorce action unless the patient or the psychiatrist on behalf of the patient testifies first to privileged communications, or (4) in any proceeding brought by the patient against his psychiatrist and in any criminal or license revocation proceeding where the patient is a complaining witness and disclosure is relevant to the claim or defense of the psychiatrist.

If the provisions of the physician-patient privilege come in conflict with those of the psychiatrist-patient privilege, the latter govern.

Medical Lien Acts

Statutes: Illinois' hospital lien law[3] applies to nonprofit and county-operated hospitals. When a lien is asserted by a hospital any defendant to the action may, upon written request, inspect the records of the injured party. A defendant may also request a written statement of the nature and extent of the injuries sustained by the plaintiff, the treatment given him and how the injuries were received, if given by the injured person and contained in the records. A comparable physician's lien has also been established.[4]

Required Reports

Statutes: Reports are required of physicians who treat children who have been subjected to physical abuse.[5]

Special Access Laws

Statutes: A recent Illinois law allows inspection and copying of a patient's hospital records by his physician or authorized attorney upon demand of the patient.[6] The act is made inapplicable to certain mental hospitals.[7]

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[1] ILL. ANN. STAT. ch. 51 § 5.1 (Smith-Hurd 1966).
[2] ILL. ANN. STAT. ch. 51, § 5.2 (Smith-Hurd Supp. 1972).
[3] ILL. ANN. STAT. ch. 82, § § 97-101 (Smith-Hurd 1966).
[4] ILL. ANN. STAT. ch. 82, § § 101.3-.5 (Smith-Hurd 1966).
[5] ILL. ANN. STAT. ch. 23, § § 2041 et seq. (Smith-Hurd Supp. 1972).
[6] ILL. ANN. STAT. ch. 51, § 71 (Smith-Hurd Supp. 1972).
[7] ILL. ANN. STAT. ch. 51, § 72 (Smith-Hurd Supp. 1972).

INDIANA

Physician-Patient Privilege

Statute: Physicians are incompetent witnesses as to matters communicated to them by patients in the course of their professional business and as to advice given in such papers.[1] It is not clear whether the privilege applies to medical records.

Case Law: The privilege is waived when a patient sues a physician for malpractice.[2] Also, if a patient puts his physical condition in issue in a personal injury suit, he waives the privilege.[3]

Regulations: An Attorney General's opinion provides that an indigent in a state hospital does not lose the privilege of confidentiality as to information in his hospital records.[4]

Public Records Acts

Statutes: The anti-secrecy law[5] excludes confidential records and thus medical records are not open to the public.

Medical Lien Acts

Statutes: The Indiana hospital lien law[6] does not provide for inspection of hospital records by parties to the action.

Required Reports

Statutes: Reports are required of physicians who treat patients with tuberculosis.[7] Any person who has reason to believe a child has been physically abused is required to report that information to a law enforcement agency or the county department of public welfare.[8] The physician-patient privilege does not exclude evidence in a proceeding arising from a child abuse report.[9]

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[1] IND. ANN. STAT § 2-1714 (4) (1968).
[2] Lane v. Boicourt, 128 Ind. 420, 27 N.E. 1111 (1891).
[3] Northern Indiana Public Service Co. v. McClure, 108 Ind. App. 253, 24 N.E.2d 788 (1940).
[4] 1945 IND. OP. ATT'Y GEN. 200.
[5] IND. ANN. STAT. § 57-606 (1961).
[6] IND. ANN. STAT. § § 43-501 to 502 (1965).
[7] IND. ANN. STAT. § § 35-1211 to 1212 (1969).
[8] IND. ANN. STAT. § § 52-1426 to 1431 (Supp. 1971).
[9] IND. ANN. STAT. § 52-1430 (Supp. 1971).

IOWA

Physician-Patient Privilege

Statutes: A physician is not allowed to reveal confidential communications entrusted to him in his professional capacity and necessary to enable him to discharge the functions of his office. However, the privilege is waived by the filing of a personal injury action.[1]

Case Law: The privilege has been held waived where a doctor was called as a witness and examined directly.[2]

Public Record Acts

Statutes: The Public Records Law recently added[3] allows the public access to records, but specifically excepts hospital records, making them confidential unless otherwise ordered by a court, the lawful custodian of the records or another person duly authorized to release information.[4]

Medical Lien Acts

Statutes: The hospital lien law[5] does not provide for inspection of hospital records.

Required Reports

Statutes: The Veneral Disease Control Act[6] requires physicians to make reports to the state health department upon examination or treatment of a diseased person. The reports are to be kept confidential to the extent necessary to prevent identification of persons named therein.

Special Access Laws

Statutes: No statute exists in Iowa specifically providing for access to hospital records.

Under Iowa common law, medical and hospital records are privileged and would not be available except to the patient.[7]

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[1] IOWA CODE ANN. § 622.10 (Supp. 1972).
[2] State v. Mayhew, 170 N.W.2d 608 (Iowa 1969).
[3] IOWA CODE ANN. § § 68A.1-.9 (Supp. 1972).
[4] IOWA CODE ANN. § 68A.7 (Supp. 1972).
[5] AIWA CODE ANN. § § 582.1-.4 (1946).
[6] IOWA CODE ANN. § § 140.1-.4 (1972).
[7] Letter from Peter J. Fox, Hearing Officer, Iowa Department of Health, to the Task Force, June 12, 1972.

KANSAS

Physician-Patient Privilege

Statute: Communications between physician and patient are privileged in civil actions and prosecutions for a misdeamenor except:

1) in an action to commit the patient for mental illness,
2) upon the issue of validity of will,
3) upon an issue between parties claiming by intestate succession, and
4) where the condition of the patient is an element of a claim or defence.[1]

Unprofessional conduct includes willful betrayal of confidential information.[2]

Psychologist-client communications enjoy the same privilege as attorney-client.[3]

Case Law: Privilege can be waived by patient[4] or his heirs[5] .

Required Reports

Statutes: Physicians must report suspected cases of child abuse,[6] to which privilege is not applicable.[7]

Special Access Laws

Statutes: Records of the mentally ill are not to be disclosed except on consent of the patient, on court order, or the proceedings under the act upon request of the patient's attorney.[8]

Regulations: Medical records are the property of the hospital. Only authorized personnel shall have access.[9]

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[1] KAN. STAT. ANN. §60-427 (1965).
[2] KAN. STAT. ANN. § 65-2837 (f) (1964).
[3] KAN. STAT. ANN. § 74-5323 (1964).
[4] Sodom v. Gemberling, 188 Kan. 716, 366 P.2d 235, 238 (1961).
[5] Fish v. Poorman, 85 Kan. 237, 116 P. 898 (1911).
[6] KAN. STAT. ANN. § 38-717 (Supp. 1970).
[7] KAN. STAT. ANN. § 38-719 (Supp. 1970).
[8] KAN. STAT. ANN. § 59-2931 (Supp. 1970).
[9] Kansas Board of Health, Hosptial Regulations § 28-34-10.

KENTUCKY

Physician—Patient Privilege

Statute: The physician-patient privilege in Kentucky is very narrow, applicable only to transactions coming within the purview of the bureau of vital statistics.[1] However, a separate statute provides that confidential communications between psychologist and client are placed on the same privileged basis as those between attorney and client, for the purposes of the chapter dealing with licensing of psychologists and the practice of psychology in the state.[2]

There is also a statutory psychiatrist-patient privilege, enacted in 1966, which applies to all proceedings.[3] It encompasses communications relating to diagnosis or treatment of the patient's mental condition between patient and psychiatrist, or between members of the patient's family and the psychiatrist, or between any of the foregoing and persons who participate in the diagnosis and treatment under the supervision of the psychiatrist. Exceptions to the privilege include:

1. when the psychiatrist determines that the patient is in need of commitment or admission to a hospital for treatment of mental illness
2. if a judge finds the patient has waived the privilege during a court-ordered psychiatric examination
3. in a civil proceeding in which the patient introduces his mental condition as an element of his claim or defense, and the judge finds that disclosure is in the interests of justice.

Case Law: Two cases make it very clear that the physician-patient privilege applies only to reports required to be filed with the bureau of vital statistics and does not render privileged communications between physician and patient generally.[4]

Special Access Laws

Regulations: A State Board of Health regulation provides that records are the property of the institution and can only be taken from the institution by court order. However, the record or a part thereof may be routed to a physician for consultation. Records are available, when requested, for inspection by duly authorized representatives of the State Board of Health.[5]

Mental patients: Records of mental patients are made confidential by statute and cannot be disclosed without the consent of the patient. However, the following exceptions are provided:

1. consent of individual
2. disclosure necessary to carry out provisions of Kentucky law
3. disclosure necessary to comply with official inquiries of federal agencies
4. court determines disclosure necessary to the proceedings before it, and failure to disclose would be contrary to the public interest.

In addition, disclosure of information as to the medical condition of the patient is allowed, upon proper inquiry to family or friends. KY. REV. STAT. § 210.235 (1972).

Medical Lab Tests: Records of laboratory may be made available to representatives of the Kentucky State Department of Health for inspection during regular office hours. KY. REV. STAT. ANN. § 333.180 (1969). *See also* §§ 333.130, 333.140 (1969).

Discovery: See also Matthew v. Farabee, 407 S.W.2d 131 (Ky. 1966); Christoff v. Downing, 309 S.W.2d. 153 (Ky. 1965); Bender v. Eaton, 343 S.W.2d. 799 (Ky. 1971).

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[1] KY. REV. STAT. § 213.200 (1972).

[2] KY. REV. STAT. ANN. § 319.111 (1969).

[3] KY. REV. STAT. ANN. § 421.215 (Cum. Supp. 1968).

[4] Boyd v. Wynn, 286 Ky. 173, 150 S.W.2d 648 (1941); Williams v. Tarter, 286 Ky. 717, 151 S.W.2d 783 (1941).

[5] Kentucky Board of Health Reg. HL-1.

LOUISIANA

Physician-Patient Privilege

Statute: There is a statutory physician-patient privilege in Louisiana which has been construed to apply only in criminal proceedings.[1] It encompasses communications made to the physician as a physician by or on behalf of his patient, or the result of examination into the patient's physical or mental condition, medical opinion, or other information. The privilege does not apply to any physician appointed by the court to investigate the patient's physical or mental condition. In addition, any physician may be cross-examined upon the correctness of any certificate issued by him. Whatever privilege a patient may have regarding communications with his doctor or hospital, once the patient institutes a suit in the prosecution or defense of which such communications or records are necessary and relevant, no privilege exists (Pennison v. Provident Life & Accident Ins. Co., see note 6, *infra*).

Case Law: The physician-patient privilege applies only to criminal proceedings. There is no physician-patient privilege in civil actions in Louisiana.[2]

Public Record Acts

Statute: Hospital records are exempt from the disclosure provisions for public records *except* when the condition of a patient admitted to a general hospital is due to an accident, poisoning, negligence or presumable negligence resulting in any injury, assault or any act of violence or a violation of the law.[3] Governing authorities of hospitals may make rules under which these reports may be exhibited and copied by those legitimately interested. According to an Attorney General Opinion of 1971, when a hospital determines that the condition of the patient is such that his hospital records are not exempted from disclosure (i.e., condition due to accident, poisoning, negligence, etc.), the records are still only available to those persons legitimately and properly interested in the disease or the condition of the patients, and the board of the hospital is authorized to make and enforce reasonable rules to determine who is legitimately interested.[4]

Special Access Laws

Statute: Superintendents of all general hospitals administered by the state must furnish upon written request of the referring doctor, a report to the doctor on the patient upon the patient's discharge.[5] Such report must show diagnosis, laboratory and x-ray findings, and treatment prescribed. Superintendents must further furnish, on written request, a full report on the patient to the patient, his attorney, or the patient's heirs or their attorney.

Case Law: A physician has been held not liable where he has made a disclosure of confidential information about his patient to her spouse. During marriage, even when the parties are living apart, the husband as head of the marital community, has the right to obtain a full medical report from his wife's doctor.[6]

Regulations: Under Louisiana law, hospital records of a medical nature are available to:[7]

1. patient's physician
2. consulting physician
3. residents and interns on a need-to-know basis in a training hospital
4. paramedical personnel on a need-to-know basis
5. the patient; after discharge, the former patient has a clear right to examine and copy his medical records. Some private hospitals have established regulations which require the consent of the patient's physician in advance of such access. However, it is the opinion of the General Counsel of the State Department of Hospitals that such regulations are contrary to Louisiana law. An unsettled question is the right of the patient to access to his hospital record *during* his stay in the hospital. It is the personal view of the General Counsel that a hospital may establish reasonable regulations governing the patient's access to his own record while he is hospitalized.
6. duly authorized representatives of the patient (e.g., attorney). The same rules that apply to the patient after discharge from the hospital apply to his representative. Again, some private hospitals have attempted to establish regulations governing access; however, the opinion of the General Counsel is that these regulations are contrary to state law.
7. in answer to a subpoena from a court of competent jurisdiction.
8. law enforcement officials in certain instances, patients who are involved in accidental trauma (e.g., car wrecks) and cases of real or suspected crimes of violence, whether the patient is the victim or the aggressor.
9. various hospital committees as provided under Medicare.[8]

In general, except as provided under Medicare, recognized educational endeavors (for statistical purposes only), and by subpoena, no one has a right to an ex-patient's hospital record without his signed consent. The ex-patient is protected under a right to privacy and in state hospitals by the exemption to the public records act discussed in II-A, *supra.* In the event of a deceased patient, access to records would be granted to his legal representative as determined in succession proceedings.

Upon transfer of a patient from one mental institution to another, all of the patient's records or a full abstract must be sent.[9]

Superintendents of state hospitals for the mentally ill must, upon written request of the coroner of the parish from which the patient was committed, furnish a report on the patient's condition. Upon written request of the patient's attorney or a near relative, the medical record must be made available for inspection.[10]

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[1] LA. REV. STAT. ANN. § 15: 476 (1967).

[2] Moosa v. Abdalla, 248 La. 344, 178 So.2d 273 (1965).

[3] LA. REV. STAT. ANN. § 44: 7, (Supp. 1972), and LA. REV. STAT. ANN. § 44: 31 (1951).

[4] LA. OP. ATT'Y GEN. March 23, 1971 and 1950-52 LA. OP. ATT'Y GEN. 202. The latter is cited from the statutory annotation to § 44: 7 (Supp. 1972).

[5] LA. REV. STAT. ANN. § 40: 2014.1 (1965).

[6] Pennison v. Provident Life & Accident Ins. Co., 154 So.2d 617 (La. App. 1963), *cert. denied,* 244 La. 1019, 156 So.2d 226 (1963). *See also* Mangrum v. Powell, 181 So.2d 400 (La. Ct. App. 1965).

[7] Letter from Thomas W. Landry, General Counsel, State Department of Hospitals, to the Task Force, June 12, 1972.

[8] See LA. REV. STAT. ANN. § 40: 2017.9 (Supp. 1972).

[9] LA. REV. STAT. ANN. §28: 94 (1969).

[10] LA. REV. STAT. ANN. § 40: 2013.3 (1965).

MAINE

Physician-Patient Privilege

Statute: Maine's privileged communications statute, which was enacted in 1969, provides that no licensed physician, in any civil or criminal action, without the patient's consent, may disclose information acquired in attending the patient in a professional capacity, if such information was necessary to enable him to furnish professional care to the patient.[1] The privilege, however, does not apply in the following cases:

1. when the physical or mental condition of the patient is at issue in the action.
2. when a court in its discretion deems disclosure necessary in the interests of justice.
3. when disclosure of information is required by law.

Medical Lien Acts

Statute: Under the hospital lien law, hospitals must make their records available in order to determine the reasonableness of charges.[2] The statute, however, forbids disclosure of records with regard to the nature of the patient's injury, condition or state of recovery.

Special Access Laws

Statute: Records of mental patients are made confidential.[3] The following exceptions exist:

1. consent of individual
2. necessity
3. court directive.

The statute also provides that information as to a mental patient's current condition may be disclosed upon inquiry to his relatives or friends. Other specified limited disclosures are allowed, e.g., to other hospitals or accredited social agencies for purposes of research. In 1966 a section was added to allow disclosure of biographical or medical information to commercial or government insurers or any other association from which the department may be reimbursed for treatment of the patient. In 1969 provisions were added to allow disclosure of information in connection with educational or training programs provided the identity of the patient remains confidential. Willful violations of the statute are punishable as misdemeanors.

Regulations: The following proposed regulations are scheduled to be adopted this summer. The regulations are substantially taken from federal regulations relating to conditions of participation for hospitals in the Federal Health Insurance for the Aged program:[4]

—medical records are confidential
—only authorized personnel have access to the records
—written consent of the patient is presented as authority for release of medical information
—medical records are not generally removed from the hospital environment except upon subpoena.

An Attorney General opinion of 1951 stated that an attorney should be granted permission to inspect any record which is open to the inspection of his client. The attorney has no stronger right than the client-patient to see the record.[5]

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[1] ME. REV. STAT. ANN. tit. 32, § 3153 (Supp. 1972).
[2] ME. REV. STAT. ANN. tit 10, § 3412 (Supp. 1972).
[3] ME. REV. STAT. ANN. tit. 34, § 2256 (Supp. 1972).
[4] Letter from Robert B. Calkins, Assistant Attorney General, to the Task Force, June 19, 1972.
[5] 1951-54 ME. ATT'Y GEN. REP. 70.

MARYLAND

Physician-Patient Privilege

Statute: Maryland has a statutory privilege for communications between patient and psychiatrist, between patient and certified psychologist, between a patient and other patients receiving group treatment, or between members of patient's family and the psychiatrist or psychologist.[1] The privilege is applicable in civil or criminal cases. However, an exception is made for cases involving the custody of children, where the court may in its discretion, compel disclosure. In addition, there is no privilege in the following situations:

1. When necessary for the purpose of placing the patient in a mental health facility.
2. if the judge finds a waiver during a court-ordered examination.
3. in any proceeding in which the patient introduces his mental condition as an element of his claim or defense
4. in malpractice actions against the psychiatrist or psychologist
5. in Art. 31B proceedings relating to defective delinquency proceedings
6. where the patient or his personal representative consents

Public Record Acts

Statute: In an exception to the disclosure provisions of the Public Record Act, citizens are denied the right to inspect medical, psychological and sociological data on individual persons, exclusive of coroners' authopsy reports, hospital records relating to medical administration, medical staff personnel, medical care, and other medical information, whether on individual persons or groups, or whether of a general or specific classification.[2]

Medical Lien Acts

Statute: Maryland's hospital lien law allows inspection of hospital records to ascertain charges and estimate the lien, provided notice of the inspection is mailed to the patient.[3]

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[1] MD. ANN. CODE art. 35 § 13A (1971).
[2] MD. ANN. CODE art. 76A § 3 (Supp. 1971).
[3] MD. ANN. CODE art 63 §49 (1972).

MASSACHUSETTS

Physician-Patient Privilege

Statutes: Massachusetts does not recognize the physician-patient privilege.

Medical Lien Acts

Statutes: The Massachusetts hospital lien law does not contain a provision for the inspection of hospital records.[1]

Required Reports

Statutes: Massachusetts law requires that any person with a veneral disease be reported to the local board of health, but makes no provision for confidentiality, leaving rules and regulations governing the area up to the state health department.[2]

A physician who has reason to believe that a child has been physically abused is required to report the injury to the department of public welfare.[3]

Special Access Laws

Statutes: A statute[4] provides for the keeping of hospital records and has, since 1945, permitted the patient or his authorized attorney to inspect the records and obtain a copy for a reasonable fee. Inspection is also permitted by judicial order but inspection of records of mental hospitals is not allowed. This early approach to the problem of access to hospital records has resulted in little difficulty in obtaining records, as reflected by the absence of cases involving the statute.

Case Law: The Supreme Judicial Court has held that the refusal to permit a patient at a mental hospital to examine and obtain copies of records of his involuntary admission and detention did not violate a constitutional provision making officers of the government accountable to the people.[5]

Regulations: The statute makes no provision for inspection of records of deceased patients. An attorney general opinion held that if a deceased patient has not executed a written authorization for an inspection of records, such an inspection may be accomplished only by judicial order.[6]

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[1] MASS, GEN. LAWS ANN. ch. 111 § § 70A-D (1971).

[2] MASS. GEN. LAWS ANN. ch. 111 § 111 (1971).

[3] MASS. GEN. LAWS ANN. ch. 119 § 39A-B (1969).

[4] MASS. GEN. LAWS ANN. ch. 111 § 70 (1971).

[5] Bane v. Superintendent of Boston State Hospital, 350 Mass. 637, 216 N.E. 2d 111 (1966), *cert. denied* 385 U.S. 842.

[6] 1963-64 MASS. OP. ATT'Y GEN. 231 (1964).

MICHIGAN

Physician-Patient Privilege

Statutes: Michigan recognizes the physician-patient privilege,[1] but the privilege is waived if a patient brings a personal injury or malpractice suit and produces a physician who has treated him as a witness in his behalf. Since expert testimony is required in most personal injury and malpractice suits in order to prove damages, the privilege would of necessity be waived in most suits of this nature. Medical records are considered confidential, also.[2]

Case Law: A recent case held that when defendant moves to depose plaintiff's physicians, plaintiff-patient must decide whether to assert the privilege or to allow deposition to continue. If the patient asserts the privilege at the deposition stage, the opposing party is precluded from obtaining privileged information, but the patient is precluded from using the privileged matters at a subsequent trial.[3] However, if the patient permits the deposition to continue, he does not waive his right to invoke the privilege at a later time.[4]

Required Reports

Statutes: Doctors are required to make reports of venereal disease,[5] tuberculosis,[6] and child abuse.[7] The physician-patient privilege does not bar testimony in cases involving child abuse.

Special Access Laws

Statutes: A recent act requires a complete record to be kept for every patient and provides that a state health official may not divulge the contents of a patient's record so as to identify an individual except on court order.[8] As this law is not specific and seems to apply only to state health officials it is of little value in obtaining access to hospital records.

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[1] MICH. COMP. LAWS ANN. § 600.2157 (1967).

[2] Letter from John L. Isbister, M.D., Michigan Department of Public Health, to the Task Force, June 13, 1972.

[3] Eberle V. Savon Food Stores, Inc., 30 Mich. App. 496, 186 N.W.2d 837 (1971).

[4] Id. at 839.

[5] MICH. COMP. LAWS ANN. § § 329.152-.202 (1967).

[6] MICH. COMP. LAWS ANN. § 329.401 (1967).

[7] MICH. COMP. LAWS ANN. § § 722.571-.574 (Supp. 1972).

[8] MICH. COMP. LAWS ANN. § 331.420 (Supp. 1972).

MINNESOTA

Physician-Patient Privilege

Statutes: A physician shall not disclose any confidential information acquired in his professional capacity without the consent of his patient.[1] The statute also provides for waiver by beneficiaries in an action to recover insurance benefits if the insurance has been in existence for two years or more.

The Minnesota Rules of Civil Procedure provide that a party waives any privilege he might have with regard to the testimony of a person who has examined him if at any stage of an action the party voluntarily places in controversy the physical, mental, or blood condition of himself, a decedent or a person under his control.[2] This rule brings Minnesota in line with the majority of states recognizing the physician-patient privilege by deeming it waived by the introduction in issue of physical or mental condition.

Regulations: Privileged matter in the records of municipally owned hospitals is not public.[3]

Medical Lien Acts

Statutes: The Minnesota hospital lien law does not provide for the inspection of hospital records.[4]

Required Reports

Statutes: Physicians are required to report incidents of child abuse,[5] and tuberculosis[6]. Reports of child abuse may be received into evidence notwithstanding the physician-patient privilege.[7]

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[1] MINN. STAT. ANN. § 595.02 (4) (Supp. 1972).
[2] MINN. R. CIV. P. Rule 35.03.
[3] 1954 MINN. OP. ATT'Y GEN. 851-K.
[4] MINN. STAT. ANN. § § 514.68-.72 (1947).
[5] MINN. STAT. ANN. § 626.554 (Supp. 1972).
[6] MINN. STAT. ANN. § 144.42 (1945).
[7] MINN. STAT. ANN. § 626.554(6) (Supp. 1972).

MISSISSIPPI

Physician-Patient Privilege

Statute: Mississippi has a privileged communications statute which applies to physicians and surgeons in any legal proceeding to bar disclosure without consent of the patient, or in case of the death of the patient, by his personal representative or legal heirs, or if the validity of the will of the decedent is in question, by the personal representative, legal heirs, or any contestant or proponent of the will.[1] The statute also implies a waiver of the medical privilege of cancer patients with regard to information necessary for the Tumor Registry Agency (to be used for statistical reports only and patient's name is not to be disclosed). There is a separate statutory right to waive the privilege given to any person who has the power to consent to surgical or medical procedures.[2] The waiver or consent survives the death of the person giving it. Waiver is not necessary for the furnishing of information to the Tumor Registry Agency.

Public Record Acts

Statute: Hospital records are not considered public records in Mississippi, except as otherwise provided by law.[3]

Required Reports

Statute: The boards of trustees of hospitals must make monthly reports to the State Hospital Commission of patients cared for, treated, and hospitalized and for which reimbursement of cost is sought.[4]

Special Access Laws

Statute: A statute expressly states that records are hospital property, subject however to reasonable access to the information contained therein upon good cause shown by the patient, his personal representatives or heirs, his attending medical personnel and his duly authorized nominees, upon payment of any reasonable charges for such service.[5]

Regulations: Due care shall be taken to prevent records from being withdrawn, destroyed or examined by unauthorized persons. The licensing agency shall be given reasonable access to the medical records for inspection and examination.[6] *Mental patients:* Records pertaining to persons committed to Mississippi State Hospital or East Mississippi Hospital are confidential. They may be divulged only by signed waiver by the person committed or by an order of a court of competent jurisdiction. An exemption is made in the case of cancer patients for information needed by the Tumor Registry Agency, which is not to disclose the identity of the patient. MISS. CODE ANN. §436-09 (Supp. 1971) *Disclosure to state agencies:* From time to time, information may be released from hospital records to state agencies. Statutes make it a misdemeanor to improperly disclose records in such cases. See, e.g., MISS. CODE ANN. §6508.5-12 and §6504.8 (1952).

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[1] MISS. CODE ANN. § 1697 (Supp. 1971).
[2] MISS. CODE ANN. § 7129-85 (Supp. 1971).
[3] MISS. CODE ANN. § 7146-59 (Supp. 1971).
[4] MISS. CODE ANN. § 7139 (Supp. 1971).
[5] MISS. CODE ANN. § 7146-53 (Supp. 1971).
[6] Minimum Standards of Operation for Hospitals Mississippi Commission on Hospital Care, § § 2401 c.d. (1966).

MISSOURI

Physician-Patient Privilege

Statute: Physicians or surgeons are incompetent witnesses as to any information acquired from any patient while attending him in a professional character and which information was necessary to treat him in a professional capacity.[1] *Waiver of privilege:* A 1968 case held that the physician-patient privilege is deemed to be waived once issue has been joined in a personal injury action as to the extent of the plaintiff's injuries, so that the defendant may obtain medical and hospital records for discovery purposes over the plaintiff's objection of privilege under the statute. State *ex rel.* McNutt v. Keet, 432 S.W.ed. 597, (1968).

Case Law: This statute applies to medical records.[2] A 1968 case held that a trial court's order allowing the plaintiff to examine numerous hospital records unmasked so he could designate those he desired produced and copied was improper as permitting the plaintiff to discover privileged matter without providing adequate safeguards.[3] A 1969 case held that this state statute could not be applied to prevent enforcement of an internal revenue summons seeking production of decedent's hospital records.[4]

Special Access Laws

Regulations: Records or excerpts can be released from the record room only on written order of the patient and his attending physician or dentist or by the legal process. They may, however, be released on the order of the administrator for purposes of research and study by qualified persons.[5]

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[1] MO. ANN. STAT. § 491.060 (1952).

[2] State *ex rel.* Benoit v. Randall, 431 S.W.2d 107 (Mo. 1968).

[3] *Id.*

[4] United States v. Kansas City Lutheran Home & Hosp. Assn, 297 F. Supp. 239 (W.D. Mo. 1969).

[5] Missouri Division of Health, Hospital Licensing Law, ch. 197 R.S. Mo.

MONTANA

Physician-Patient Privilege

Statute: Physician cannot be examined in a civil action as to information acquired in attending patient without the consent of his patient.[1] Privilege is waived by commencing action which places in issue the physical or mental condition of the party.[2]

A psychologist employed by an educational institution cannot be examined as to communications made to him in confidence by a duly registered student of such institution unless by consent of the student, or, if a minor, by student and his parents.[3]

Psychologist-client communications are privileged on the same basis as attorney-client communications.[4]

Case Law: Privilege can be waived only by patient, not by doctor.[5]

Privilege statute does not apply to criminal actions.[6]

Required Reports

Statute: Physicians must report suspected cases of child abuse,[7] reports of which are not to be excluded from evidence on the ground of privilege.[8]

Physicians must also report cases of venereal disease,[9] but information concerning persons infected can only be released to state department of health or a physician upon written consent of the person whose record is requested.[10]

Special Access Laws

Regulations: Hospital records are to be kept confidential. They are the property of the hospital and may be removed from the hospital only with official permission. Only authorized personnel may have access to the records. Written consent of the patient must be presented as authority for release of identifiable medical information.[11]

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[1] MONT. REV. CODES ANN. § 93-701-4(4) (1963).

[2] MONT. R. CIV. P. 35(b) (2) (Supp. 1971).

[3] MONT. REV. CODES ANN. § 93-701-4(7) (Supp. 1971).

[4] MONT. REV. CODES ANN. § 66-3212 (Supp. 1971).

[5] Hier v. Farmers Mut. Fire Ins. Co., 104 Mont. 471, 67 P.2d 831, 837 (1937).

[6] State v. Campbell, 146 Mont. 251, 405 P.2d 978, 984 (1965). Unlike the section covering physicians, the section creating a psychologist-client privilege is not expressly limited to civil actions.

[7] MONT. REV. CODES ANN. § 10-902 (1967).

[8] MONT. REV. CODES ANN. § 10-905 (1967).

[9] MONT. REV. CODES ANN. § 69-4604 (1969).

[10] MONT. REV. CODES ANN. § 69-4610 (Supp. 1971).

[11] Montana Board of Health Regulations § 31.106.

NEBRASKA

Physician-Patient Privilege

Statutes: Nebraska recognizes the physician-patient privilege,[1] but the privilege is deemed to have been waived, as to both the testimony of a physician and hospital records, if the patient files an action (1) seeking to recover damages for personal injuries or (2) in which his physical or mental condition is an issue.[2] The privilege may also be waived by the bringing of a similar action by the personal representative of a deceased person.[3]

Case Law: The Eighth Circuit permitted an insurance company which received authorization from patients to inspect hospital records unless the patient's doctor, in the exercise of good faith judgment, certified under oath that the records should not be released, in the best interests of the patient's health.[4] The court held that the physician-patient privilege was waived by the patient's authorization.

Public Record Acts

Statute: Nebraska gives citizens the right to examine public records unless otherwise provided by law.[5] There does not appear to be an exception made for hospital records in Nebraska's statutes or regulations.

Medical Lien Acts

Statutes: Nebraska's hospital lien law does not provide for the inspection of hospital records.[6]

Required Reports

Statutes: Nebraska requires physicians to test pregnant women for syphilis.[7] Nebraska does not appear to require reports of battered children, tuberculosis, or venereal disease.

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[1] NEB. REV. STAT. § 25-1206 (1964).
[2] NEB. REV. STAT. § 25-1207 (1964).
[3] *Id.*
[4] Bishop Clarkson Memorial Hosp. v. Reserve Life Ins. Co., 350 F.2d 1006 (8th Cir. 1966).
[5] NEB. REV. STAT. § 84-712 (1966).
[6] NEB. REV. STAT. § § 52-401 to -402 (1968).
[7] NEB. REV. STAT. § 71-1117 (1971).

NEVADA

Physician-Patient Privilege

Statute: A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications among himself, his doctor or persons who are participating in the diagnosis or treatment under the direction of the doctor, including members of the patient's family.[1] The privilege may be claimed by the patient, but by the doctor only on behalf of the patient.[2] There is no privilege (1) in proceedings to hospitalize for mental illness, (2) for court-ordered examinations, or (3) where the condition of the patient is an element of a claim or defense.[3]

Records of treatment of narcotic addicts are privileged.[4]

Public Record Acts

Statute: Public records act allows the inspection of records "the contents of which are not otherwise declared by law to be confidential."[5]

Medical Lien Acts

Statute: Party against whom a claim is asserted has the right to examine and make copies of the records connected to the hospitalization of the injured person.[6]

Required Reports

Statute: Suspected cases of child abuse must be reported,[7] and such reports are admissible in evidence regardless of whether they would otherwise be privileged.[8] Reports of cases of venereal disease are not required to include the name of the patient.[9] Reports must also be made of cases of communicable disease[10] and epilepsy.[11]

Special Access Laws

Statute: Records of persons hospitalized in a public hospital for mental illness shall be made available, upon the person's written authorization, to his attorney or personal physician.[12]

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[1] NEV. REV. STAT. § § 49.215-.245 (1971). § 49.215 includes psychologists.
[2] NEV. REV. STAT. § 49.235 (1971).
[3] NEV. REV. STAT. §49.245 (1971).
[4] NEV. REV. STAT. § 453.720 (1971).
[5] NEV. REV. STAT. § 239.010(1) (1971).
[6] NEV. REV. STAT. § 108.640 (1971).
[7] NEV. REV. STAT. § 200.502 (1971).
[8] NEV. REV. STAT. § 200.506 (1971).
[9] NEV. REV. STAT. § 441.110 (1971).
[10] NEV. REV.STAT. § 439.210 (1971).
[11] NEV. REV. STAT. § 439.270 (1971).
[12] NEV. REV. STAT. § 433.721 (1971).

NEW HAMPSHIRE

Physician-Patient Privilege

Statute: In 1969 New Hampshire enacted a privileged communications statute which places the privilege between a physician or surgeon and his patient on the same basis as the attorney-client privilege.[1] A separate statute creates a parallel privilege between psychologist and client.[2]

Public Record Acts

Statute: Medical records are exempt from the disclosure provisions relating to public records.[3]

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[1] N.H. REV. STAT. ANN. § 329:26 (Supp. 1971).
[2] N.H. REV. STAT. ANN. § 330-A:19 (Supp. 1971).
[3] N.H. REV. STAT. ANN. § 91-A:5 (Supp. 1971).

NEW JERSEY

Physician-Patient Privilege

Statute: The confidential communications statute in New Jersey prevents a witness from disclosing a communication, if the privilege is claimed and if the judge finds, inter alia, that the communication was a confidential one between patient and physician.[1] The privilege applies in civil and criminal actions, including juvenile delinquency proceedings. There are numerous exceptions created by subsequent statutes, including the following:

1. actions to commit a patient to a mental hospital
2. action in which the patient seeks to establish his competence
3. actions to recover damages on account of the criminal conduct of the patient
4. actions contesting the validity of wills
5. actions in which the condition of the patient is an element of the claim or defense
6. information which the physician or the patient is required to report to public officials
7. actions where the services of the physician were obtained to aid the commission of a crime or tort or to escape detection.

The statute also makes provisions for the disclosure of information by hospital utilization review committees.

Case Law: This statute applies to hospital records.[2] A 1969 case held that in a custody proceeding the plaintiff's motion to inspect medical records would be denied under the statutory privilege, except to the limited extent that the records could be subpoenaed for inspection by the court.[3] The provision of the statute which exempts from the privilege hospital records in an action to commit the patient to a mental hospital does not operate to remove from the privilege records of hospitalization which resulted from commitment proceedings, where there is an attempt to use such records in subsequent unrelated litigation.[4]

Public Record Acts

Statute: Any person against whom a claim is asserted for compensation or damages for personal injuries or death resulting from personal injuries, either under the Workmen's Compensation Act or at law, or his insurance carrier may examine hospital records in reference to such person.[5]

Any person who has been injured or his legal representative who has asserted or will assert a claim has the same right of examination of hospital records. These provisions apply to the attorneys of the respective parties as well, subject to reasonable rules promulgated by the hospital. There is to be no liability for permitting such examination.

Medical Lien Act

Statute: In New Jersey hospitals and nursing homes must allow any persons legally liable for a lien or against whom a claim for damages for injuries is asserted, to inspect records.[6] Failure to allow such examination is a valid defense in an action brought to enforce the lien.

Special Access Laws

Regulations: *Mental patients:* Medical records identifying any individual presently or formerly receiving services in a non-correctional state institution are confidential and may not be disclosed. Exceptions:

1. Consent of individual
2. necessity
3. court directive

The statute provides that upon inquiry, information as to the patient's medical condition may be given to a relative, friend, patient's physician or attorney, if it appears that the information is to be used directly or indirectly for the benefit of the patient. N.J. STAT. ANN. § 30: 4-24.3 (Supp. 1971)

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[1] N.J. REV. STAT. § § 2A: 84A-22.2-.9 (Supp. 1971).

[2] Unick v. Kessler Memorial Hosp., 107 N.J. Super. 121, 257 A.2d 134 (1969).

[3] D. v. D., 108 N.J. Super. 149, 260 A.2d 255 (1969).

[4] *Id.*

[5] N.J. REV. STAT. § § 2A; 82-41 to 45 (1952). *See also* N.J. REV. STAT. § § 47: 1A-1 *et seq.* (Supp. 1972), which provides that public records are open for inspection by the general public, with certain exceptions for the protection of public interest.

[6] N.J. REV. STAT. § § 2A: 44-45 (Supp. 1971).

NEW MEXICO

Physician-Patient Privilege

Statutes: Privilege applies only to communications with reference to venereal or loathsome disease and to communications with personal physicians in workmen's compensation cases.[1]

Privilege may be waived if person offers himself as a witness and voluntarily testifies as to such communications.[2]

Privilege extends to psychologist-client communications.[3]

Information of drug violations obtained by drug abuse rehabilitation facilities is not subject to disclosure.[4] However, information communicated to physicians in an effort to procure unlawfully narcotic drugs is not privileged.[5]

Unprofessional or dishonorable conduct includes, among other things, wilfully or negligently divulging a professional secret.[6]

Public Records Acts

Statute: Open records act expressly exempts medical records.[7]

All health information that identifies specific individuals as patients is strictly confidential and shall not be a matter of public record or accessible to the public even though contained in the records of governmental agency.[8]

Required Reports

Statute: Venereal disease reports are not required to include names: information and reports are confidential and inaccessible to the public.[9]

Special Access Laws

Statute: Disclosure of records of mental patients is not allowed except upon the consent of the patient or as a court may direct.[10]

Regulations: "In practice, information is released only with the consent of the patient."[11]

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[1] N.M. STAT. ANN. § 20-1-12(d) (1970).
[2] N.M. STAT. ANN. § 20-1-12(f) (1970).
[3] N.M. STAT. ANN. § 67-30-17 (Supp. 1971).
[4] N.M. STAT. ANN. § 54-10-13 (Supp. 1971).
[5] N.M. STAT. ANN. § 54-7-44 (1962).
[6] N.M. STAT. ANN. § 67-5-9(5) (Supp. 1971).
[7] N.M. STAT. ANN. § 71-5-1 (1961).
[8] N.M. STAT. ANN. § 12-18-1 (Supp. 1971).
[9] N.M. STAT. ANN. § 12-3-5 (1968).
[10] N.M. STAT. ANN. § 32-2-18 (1953).
[11] Letter from Julia C. Southerland, Chief Attorney, New Mexico Health and Social Services Department to the Task Force, June 13, 1972.

NEW YORK

Physician-Patient Privilege

Statutes: New York recognizes the privileged nature of information acquired by doctors, dentists and nurses in their professional capacity, and which was necessary to enable the practitioner to act in that capacity.[1] The privilege can be waived by the patient.

Information privileged under the statute can be disclosed after the patient's death, except that the privilege remains in force for information that would tend to disgrace the memory of the patient. The privilege can be waived by the deceased patient's surviving spouse, personal representative, or next of kin.[2]

Case Law: The privilege cannot be claimed by a party for a non-party patient.[3]

The New York Court of Appeals recently held that the privilege of a patient is waived by the bringing or defending of a personal injury action in which the physical or mental condition of the patient is affirmatively put in issue.[4] However, a defendant does not put his condition in issue merely by denying the allegations of the complaint.

Medical Lien Acts

Statutes: The New York hospital lien law does not provide for the inspection of hospital records.[5]

Required Reports

Statutes: New York law requires physicians to report cases of venereal disease,[6] tuberculosis,[7] and child abuse.[8]

Special Access Laws

Statutes: When a subpoena *duces tecum* which requires the production of medical records is served upon a hospital, city or state department, a transcript or copy certified as correct may be produced unless otherwise ordered by a court.[9]

After an action is begun in which the mental or physical condition of a party, agent, employee, etc., is in controversy, any party may serve notice on another party to submit to a physical or mental examination. The notice may require duly executed and acknowledged written authorizations permitting all parties to obtain and make copies of records of specified hospitals relating to the mental or physical condition in controversy. A party who obtains a copy of a hospital record as a result of the authorization of another party is required to deliver a duplicate to that party.[10]

Case Laws: The New York Supreme Court has held that the physical or mental condition of a party must merely be in controversy to obtain an examination and records; it does not have to be in issue.[11]

A hospital cannot withhold a patient's records to prevent him from discovering the identity of the doctors who operated on or treated him.[12]

Regulations: Regulations allow hospitals to establish procedures governing the release of information from patients' medical records.[13]

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[1] N.Y. CIV. PRAC. LAW § 4504(a) (McKinney Supp. 1971).
[2] N.Y. CIV. PRAC. LAW § 4504(c) (McKinney Supp. 1971).
[3] People v. Preston, 176 N.Y.S.2d 542 (Kings County Ct. 1958).
[4] Koump v. Smith, 25 N.Y.2d 287, 250 N.E.2d 857, 303 N.Y.S 2d 858 (1969).
[5] N.Y. LIEN LAW § 189 (McKinney 1966).
[6] N.Y. PUB. HEALTH LAW § 2300 (McKinney 1971).
[7] N.Y. PUB. HEALTH LAW § 2221 (McKinney 1971).
[8] N.Y. SOC. SERV. LAW § 383a (McKinney Supp. 1972).
[9] N.Y. CIV. PRAC LAW § 2306(a) (McKinney 1963).
[10] N.Y. CIV. PRAC. LAW § 3121 (McKinney 1963).
[11] Fisher v. Fossett, 45 Misc.2d 757, 257 N.Y.S.2d 821 (Sup. Ct. 1965).
[12] Application of Weiss, 208 Misc. 1010, 147 N.Y.S.2d 455 (Sup. Ct. 1955).
[13] 10 Official Compilation of Codes, Rules and Regulations § 720.20(p) (1971).

NORTH CAROLINA

Physician-Patient Privilege

Statute: Information acquired in treating patients is privileged from disclosure except that the court, either prior to or at trial, may compel disclosure if necessary to a proper administration of justice.[1]

There is a statutory exception for child abuse cases.[2]

The privilege has been extended to cover psychologist-client communications.[3]

Information pertaining to treatment of drug dependant persons is confidential and inadmissible in evidence.[4]

Case Law: Privilege may be waived by patient but not by doctor.[5] Privilege may also be waived by patient's testifying in great detail as to his physical condition.[6]

Regulations:–

Public Record Acts

Statute: Public records inspection statute does not expressly exempt medical records.[7] However, the Attorney General, in a letter responding to an inquiry from a state health official, stated that it was his opinion that the compiling of clinical records does not constitute "transaction of public business" within the meaning of the statute and that such records should not be made available for public inspection.[8]

Required Reports

Statutes: Abortions are to be reported, but such reports are for statistical purposes only and confidenitality of patient relationship is to be protected.[9]

Reports of cancer[10] venereal disease[11] and bites of rabid dogs are also required.

Special Access Laws

Statute: Records of mental patients are not to be disclosed except upon court order.[13]

Regulations: Hospital records may not be taken from a hospital except under a subpoena.[14]

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[1] N.C. GEN. STAT. § 8-53 (1969).

[2] N.C. GEN. STAT. §8-53.1; §110-121 (Supp. 1971).

[3] N.C. GEN. STAT. §8-53.3 (Supp. 1971).

[4] N.C. GEN. STAT. § 90-109.1(a) (Supp. 1971).

[5] Yow v. Pittman, 241 N.C. 69, 84 S.E.2d 297, 298 (1954).

[6] Capps v. Lynch, 253 N.C. 18, 116 S.E.2d 137, 142 (1960).

[7] N.C. GEN. STAT. § § 132-1, -6 (1964).

[8] Letter from George B. Patton, Attorney General of North Carolina, to Dr. O. David Garvin, District Health Officer, Chapel Hill, N.C., in response to letter dated Feb. 13, 1958.

[9] N.C. GEN. STAT. § 14-45.1 (Supp. 1971).

[10] N.C. GEN. STAT. § 130-184 (1964).

[11] N.C. GEN. STAT. § 130-95 (1964).

[12] N.C. GEN. STAT. § 106-380 (1966).

[13] N.C. GEN. STAT. § 122-8.1 (1964).

[14] N.C. Medical Care Comm'n, 14 *Laws, Regulations and Procedures Applying to Licensing of Hospitals* 39.

NORTH DAKOTA

Physician-Patient Privilege

Statutes: A physician cannot be examined as to information acquired in attending the patient or as to any communication made by the patient to him in the course of his professional employment.[1] This statement of the physician-patient privilege is similar to the language used in many other states and it presumably applies to hospital records.

North Dakota law also provides that the privilege is waived if a person (patient) testifies as a witness to a subject privileged under the physician-patient privilege.[2]

Public Record Acts

Statutes: Hospital records are not specifically excluded from the statute giving the public access to records,[3] but the regulations governing hospital records[4] may come within the wording of the statute "except as otherwise specifically provided by law" and bar access to records of public hospitals.

Medical Lien Acts

Statutes: The North Dakota hospital lien act allows inspection of hospital records by the party against whom the lien is asserted, i.e., the defendant.[5]

Required Reports

Statutes: North Dakota law requires physicians to report cases of venereal disease[6] and child abuse or neglect[7] and provides that evidence disclosed in the latter type of report is not privileged.

Special Access Laws

Regulations: State Hospital Regulations state that medical records shall be confidential, that only authorized personnel shall have access to the records, that written consent of the patient shall be presented for release of medical information and that hospital records generally should not be removed from the "hospital environment" except by subpoena.[8]

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[1] N.D. CENT. CODE § 31-01-06(3) (Supp. 1972).

[2] N.D. CENT. CODE § 31-01-07 (1960).

[3] N.D. CENT. CODE § 44-04-18 (1960).

[4] See *infra*, note 8.

[5] N.D. CENT. CODE § 35-18-09 (1960).

[6] N.D. CENT. CODE § 23-07-02 (1960).

[7] N.D. CENT. CODE § 50-25-01 to -05 (Supp. 1971).

[8] *Rules and Regulations for Hospitals and Related Institutions.* R 23-16-8 A.1-.3.

OHIO

Physician-Patient Privilege

Statutes: Ohio recognizes the physician-patient privilege, which may be waived by the express consent of the patient, a surviving spouse or personal representative, or by the voluntary testimony of the patient.[1]

Case Law: The Ohio Supreme Court has held[2] that the physician-patient privilege must be strictly construed since it is in derogation of the common law. Only communications between a physician and patient, not in the presence of a third person, are to be considered privileged communications.

A defendant may not inspect plaintiff's hospital records over plaintiff's objection of privilege by taking the deposition of the record librarian because the question of what portion of a hospital record is privileged and what is not is a judicial determination beyond the capabilities of a notary.[3]

Plaintiff was ordered before trial to produce records of doctors in her possession or which would come into her possession before trial if plaintiff contemplated waiver of her physician-patient privilege.[4]

However the Ohio Supreme Court recently held that a personal injury litigant does not waive the physician-patient privilege merely by filing his petition and that a court cannot compel disclosure of personal medical records.[5]

A lower court later held that the physician-patient privilege does not apply in malpractice cases.[6]

Thus, some portions of the hospital record are privileged, but it is not clear from the cases how the determination of privilege is to be made.

Public Record Acts

Statutes: Ohio law provides for state and county record departments, but excludes records of county hospitals from the records covered.[7]

Required Reports

Statutes: Ohio requires physicians and others to report cases of child abuse.[8]

Special Access Laws

Case Law: The Supreme Court has held that when a request is made to inspect hospital records, the hospital may permit a former patient to see as much of his records as the hospital deems to be in the beneficial interest of the patient. If unsatisfied, the patient may commence an action to require the furnishing of the entire record.[9]

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[1] OHIO REV. CODE ANN.§ 2317.02(A) (Page 1954).

[2] Weis v. Weis, 147 Ohio St. 416, 72 N.E.2d 245 (1947).

[3] Heinemann v. Mitchell, 8 Ohio Misc. 390, 220 N.E.2d 616 (Ct. C.P. Hamilton County 1964).

[4] Greene v. Sears, Roebuck & Co., 40 F.R.D. 14 (N.D. Ohio 1966); Lambdin v. Leonard, 20 Ohio Misc. 189, 251 N.E.2d 165 (Ct. C.P. Montgomery County 1968), *rev'd sub. nom.* State *ex rel.* Lambdin v. Benton, 21 Ohio St.2d, 254 N.E.2d 681 (1970).

[5] State *ex rel.* Lambdin v. Benton, 21 Ohio St.2d 254 N.E. 2d 681 (1970).

[6] Otto v. Miami Valley Hosp. Soc'y, 26 Ohio Misc. 72, 166 N.E.2d 270 (Ct. C.P. Montgomery County 1971).

[7] OHIO REV. CODE ANN. § § 149.32-.40 (Page 1969).

[8] OHIO REV. CODE ANN. § 2151.42.1 (Page 1968).

[9] Wallace v. University Hosps., 171 Ohio St. 487, 172 N.E.2d 459 (1961).

OKLAHOMA

Physician-Patient Privilege

Statutes: Physician is incompetent to testify in civil and criminal actions with reference to patient's communications or knowledge obtained by personal examination of the patient. The privilege is waived if the party offers himself or physician as a witness.[1]

Under the rules of Civil Procedure a party can get a copy of the report of an examination required by an adverse party without having to turn over all other pertinent medical records as to the condition examined.[2]

Unprofessional conduct is defined as, in part, wilfully betraying a professional secret to the detriment of the patient.[3]

All communications relating to the treatment of drug dependents are confidential.[4]

Case Law: A party does not waive the privilege by placing in issue his own physical condition.[5]

Public Record Acts

Statute: Statute permitting public inspection of public records does not apply to "other records required by law to be kept secret."[6]

Required Reports

Statute: Physicians are required to report cases of child abuse[7] and privilege does not affect admissibility of such reports.[8] Cases of venereal disease must also be reported, but such reports are inaccessible to the public.[10]

Special Access Laws

Statute: Case records of former medical patients may, with the patient's consent, be furnished to community health services, social agencies and private physicians who are engaged in a therapeutic endeavor with the former patient.[11]

Case Law: Patient has property right in information appearing or portrayed on hospital records and he, or those authorized by him, is entitled to make such inspection and/or copy such records without resort to litigation.[12]

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[1] OKLA. STAT. ANN. tit. 12, § 385 (6) (1960).

[2] OKLA. STAT. ANN. tit. 12. § 425 (Supp. 1971).

[3] OKLA. STAT. ANN. tit. 43A, § 657 (Supp. 1971).

[4] OKLA. STAT. ANN. tit. 59, § 509 (Fourth) (1971).

[5] Avery v. Nelson, 455 P.2d 75, 78 (1969).

[6] OKLA. STAT. ANN. tit. 51, § 24 (1962).

[7] OKLA. STAT. ANN. tit. 21, § 846 (Supp. 1971).
[8] OKLA. STAT. ANN. tit. 21, § 848 (Supp. 1971).
[9] OKLA. STAT. ANN. tit. 63, § 1-528(b) (1964).
[10] OKLA. STAT. ANN. tit. 63, § 1-532 (1964).
[11] OKLA. STAT. ANN. tit. 43A, § 18 (13) (Supp. 1971).
[12] Pyramid Life Ins. Co. v. Masonic Hosp. Ass'n, 191 F.Supp. 51,54 (1961).

OREGON

Physician-Patient Privilege

Statute: Physician may not be examined in a civil action, without the consent of his patient, as to information acquired in attending patient.[1] Privilege is waived if party offers himself as a witness.[2]

Psychologist cannot be examined without the consent of his patient as to any communications made by his client to him or advice given by him in the course of professional employment.[3]

Case Law: Physician-patient privilege is not applicable to criminal proceedings.[4]

A party does not waive privilege by filing an action for personal injuries or when called involuntarily to testify at trial or on deposition.[5]

Other: "No lawyer should request and no physician should furnish any information concerning the history, physical condition, diagnosis or prognosis of a patient except upon written authorization of the patient."[6]

Medical Lien Acts

Statute; Any party legally liable or against whom a claim has been asserted may examine and make copies of hospital records in reference to the hospitalization of the injured person.[7]

Required Reports

Statute: Physicians are required to report cases of injuries suspected to be caused by violence;[8] such reports are confidential and not accessible for public inspection.[9]

Special Access Laws

Regulations: Medical records are the property of the hospital and shall not be removed except where necessary for a judicial or administrative proceeding.[10]

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[1] ORE. REV. STAT. § 44.040(1) (d) (1971).
[2] ORE. REV. STAT. § 44.040(2) (1971).
[3] ORE. REV. STAT. § 44.030(h) (1971).
[4] State v. Betts, 235 Ore. 127, 384 P.2d 193 (1963).
[5] Nielson v. Bryson, 477 P.2d 714 (Ore. 1970).
[6] State Bar Association and Oregon State Medical Society, "Statement of Principles Governing Certain Physician-Lawyer Relationships."
[7] ORE. REV. STAT. § 441.510 (1971).
[8] ORE. REV. STAT. § 146.750 (1971).
[9] ORE. REV. STAT. § 146.780(2) (1971).
[10] Oregon Administrative Rules ch. 33 § 3-190(11) (1972).

PENNSYLVANIA

Physician-Patient Privilege

Statute: Under the Pennsylvania privileged communications statute, which applies only in civil cases, physicians and surgeons may not disclose any information acquired in attending the patient in a professional capacity, which tends to blacken the character of the patient, without the patient's consent.[1] However, the privilege is inapplicable in civil actions brought by the patient to recover damages for personal injuries.

Case Law: Hospital records on theraputic abortion contain privileged communications within the meaning of the statute and can not be divulged without the consent of the parties affected.[2]

Required Reports

Statutes: Physicians must report cases of contagious diseases.[3]

Special Access Laws

Case Law: In a 1962 case, the court condemned the action of a physician in submitting a report on the plaintiff-patient to a doctor employed by her antagonist in litigation.[4]

Regulations: The topic of discovery and access to medical records appears primarily to be controlled by the Pa. Rules of Civil Procedure. Hospital records are within the scope of Rule 4009—right to inspection, *Yankovich v. Dicks*, 14 Pa.D&C.2d 53 (1957). However, discovery of records may be restricted to the specific relevant parts. *Matychuck v. Purnell*, 11 Pa.D&C.2d 507 (1957). Discovery is of course subject to the limitation that records created in anticipation of litigation or in preparation for trial are not discoverable. Where the patient's sobriety or intoxication are at issue, relevant parts of hospital records may be inspected on motion of the plaintiff, *Rearick v. Griffith*, 27 Pa.D&C.2d 451 (1962). See also *Herman v. Daly*, 33 Pa.D&C.2d 164 (1964).

Mental patient situations have a special regulation. In general, records of those who are admitted or committed to mental institutions are open to inspection only to those persons designated by the director of the facility.[5]

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[1] PA. STAT. ANN. tit. 28, § 328 (1958).
[2] Berman v. Duggan, 119 P.J.L. 272, 1971 (case not available, case cited from PA. STAT. ANN. tit. 28, § 328 [Supp, 1972].)
[3] PA. STAT. ANN. tit. 53, § 24663 (1957).
[4] Alexander v. Knight, 197 Pa. Super. 79, 177 A.2d 142 (1962).
[5] PA. STAT. ANN. tit. 50, § 4602 (1969), *see also*, PA. STAT. ANN. tit. 50, § 4605 (5), which makes it unlawful for any person to disclose without authority the contents of any persons, admitted or committed.

RHODE ISLAND

Medical Lien Acts

Statute: Under Rhode Island law, any person, firm, or corporation legally liable for a hospital lien or against whom a claim for compensation for injuries are asserted, may examine hospital records in reference to treatment, care and maintenance.[1]

Required Reports

Statutes: Physicians must file reports of all cases of occupational diseases.[2]

Special Access Laws

Regulations: Records are the property of the hospital. The institution may restrict the removal of the record from its premises subject to the intervention of the court. The patient has an undeniable right and interest in the contents of the record, although he may have to protect this interest through recourse to the courts.[3]

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[1] R.I. GEN. LAWS ANN. § 9-3-7 (1969).
[2] R.I. GEN. LAWS ANN. § 23-5-5 (1969).
[3] Letter from Justice Joseph R. Weisberger, Superior Court of Rhode Island, to Dr. David L. Starbuck, M.D., Division of Epidemiology, Rhode Island State Department of Public Health, Sept. 9, 1971.

SOUTH CAROLINA

Physician-Patient Privilege

Case Law: In the absence of a statutory privilege, the common-law rule that there is no privilege prevails in this state.[1]

Required Reports

Statute: Physicians are required to report cases of venereal disease[2] and other contagious diseases.[3]

Special Access Laws:

Statutes: Records of mental patients are not to be disclosed except:

1. upon consent of the parent or guardian
2. upon court order
3. as necessary as cooperating with Federal agencies in furthering the welfare of the patient or his family
4. as necessary in cooperation with law enforcement agencies
5. when public safety is involved.[4]

Similar statutes govern disclosure of records of persons treated for alcoholism or drug addiction.[5]

Regulations: Hospital records of patients are the property of the institution and must not be taken from the hospital property except by court order.[6]

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[1] Peagler v. Atlantic Coast Line R.R., 232 S.C. 274, 101 S.E. 2d 821,825 (1958).
[2] S.C. CODE ANN. § 32-593 (Supp. 1971).
[3] S.C. CODE ANN. § 32-552 (Supp. 1971).
[4] S.C. CODE ANN. § 32-1022 (Supp. 1971).
[5] S.C. CODE ANN. § 32-995.18 (Supp. 1971).
[6] So. Carolina State Board of Health, *Minimum Standards for Licensing in South Carolina Hospitals*, §501.4 (1968).

SOUTH DAKOTA

Physician-Patient Privilege

Statute: South Dakota recognizes the physician-patient privilege which prohibits a physician from being examined in a civil action as to information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient without the consent of the patient.[1] Hospital records of a patient's diagnosis and treatment are considered an extension of the patient's privilege.[2]

Case Law: The Supreme Court of South Dakota has held that the physician-patient privilege is to be liberally construed in favor of the patient.[3]

Medical Lien Laws:

Statutes: The Law in South Dakota provides for the inspection of hospital records.[4]

Required Reports

Statutes: South Dakota requires physicians to report cases of venereal disease[5], tuberculosis[6], and child abuse[7]. Reports of the latter are not considered privileged communications.[8]

Special Access Laws

Statutes: The legislature has put all hospitals under the jurisdiction of the State Department of Health and requires them to maintain records.[9] The legislature has also prohibited disclosure of information received by the Department of Health, except through judicial order or as otherwise provided by law.[10] Whether statutes make hospital records confidential is unclear.

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[1] S.D. COMPILED LAWS ANN. § 19-2-3- (1967).
[2] Memorandum from Assistant Attorney General to the Secretary of State, at 3 (see appended material to this section).
[3] Hogue v. Massa, 80 S.D. 319, 123 N.W.2d 131 (1963).
[4] S.D. COMPILED LAWS ANN. § 44-12-9 (1967).
[5] S.D. COMPILED LAWS ANN. § 34-23-2 (1967).
[6] S.D. COMPILED LAWS ANN. § 34-22-25 (Supp. 1972).
[7] S.D. COMPILED LAWS ANN. § 26-10-10 (1967).
[8] S.D. COMPILED LAWS ANN. § 26-10-15 (1967).
[9] S.D. COMPILED LAWS ANN. § 34-12-15 (1967).
[10] S.D. COMPILED LAWS ANN. § 34-12-17 (1967).

TENNESSEE

Physician–Patient Privilege

Statute: A psychiatrist-patient privilege was enacted in 1965.[1] It does not apply in civil or criminal cases in which the mental condition of the patient is at issue or where the court determines that the privilege should be withheld in the interests of justice.

A chapter dealing with voluntary patients in mental hospitals provides that records made for the purpose of that chapter which directly or indirectly identify a patient or former patient are confidential. Exceptions are made for (1) consent of individual, (2) necessity, and (3) court directive. Disclosure of information as to the patient's medical condition may be made upon inquiry to the patient's family and friends.[2]

Case Law: There is no physician-patient privilege in Tennessee. Even if there were one relating to evidence at trial, it would have no bearing in a case where information was communicated out of court to a third party who, in the event of suit, would have had access to the report under discovery procedures anyway.[3]

Public Record Acts

Statute: Medical records of patients in state hospitals and medical facilities and records of patients receiving state financial assistance are confidential and not open to public inspection.[4] Information is to be disclosed to the public only in compliance with a subpoena or court order.

Special Access Laws

Regulations: Records are the property of the institution and are confidential.[5] They must not be removed from the institution and must remain confidential except by court order. However, excerpts may be routed to physicians or to institutions for consultation. Medical records are made available upon request to representatives of the Hospital Licensing Board or the State Department of Public Health.

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[1] TENN. CODE ANN. § 24-112 (Supp. 1971).
[2] TENN. CODE ANN. § 33-1208 (Supp. 1971).
[3] Quarles v. Sutherland, 215 Tenn. 651, 389 S.W.2d 249 (1964).
[4] TENN. CODE ANN. § 15-305 (Supp. 1971).
[5] Tennessee Dept. of Pub. Health, Minimum Standards and Regulations for Hospitals § 801.3 (1966).

TEXAS

Medical Lien Acts

Statute: Under the Texas hospital lien law, persons against whom a claim for compensation for injuries has been filed may examine hospital records in reference to the treatment, care and maintenance of the injured person.[1]

Special Access Laws:

Case Law: In a 1970 malpractice action, a Texas court refused to permit plaintiff's counsel to examine county medical society records made six years after the surgery in question, on the grounds it was an attempt to inquire into irrelevant matters and to impeach the defendant-physician on collateral matters.[2]

Regulations: Regulations provide that the hospital owns the hospital records.[3] Although a signed authorization is preferred, the hospital may send records to another hospital or doctor caring for the patient without the patient's consent, but the hospital may be running the risk of a suit for breach of a confidential relationship or invasion of privacy. If there is a court order, of course, the patient's consent is not required. If the hospital is sued by the patient, the hospital may use the records in defense.

One article of the Texas law provides that hospital records of mental patients are confidential except in the following situations:

1. consent of the individual
2. necessity
3. court directive
4. chief administrator feels that it is the best interest of the patient to release the information.[4]

Information as to the patient's current condition may be disclosed to the family, relatives or friends of the patient.[5]

Records of persons applying for medical assistance are confidential,[6] as are records of any hospital committee.[7]

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[1] TEX. REV. STAT. art. 5506a § 4a (1958).
[2] Goodnight v. Phillips, 458 S.W.2d 196 (1970).
[3] Letter enclosing pamphlet from Hal Nelson, Legal Consultant, Texas State Department of Health—Texas Hospital Association, June 13, 1972.
[4] TEX. REV. STAT. art. 5547-87 (1958).
[5] *Id.*
[6] TEX. REV. CIV. STAT. ANN. art. 695j-1 (Supp. 1972).
[7] TEX. REV. CIV. STAT. ANN. art. 4447d (Supp. 1972).

UTAH

Physician-Patient Privilege

Statute: A physician, without the consent of his patient, cannot be examined in a civil action as to information acquired in attending patient.[1]

A psychologist cannot be examined in a civil or criminal action as to information acquired in the course of his professional services.[2]

Information communicated to a physician in an effort to unlawfully procure a narcotic drug is not privileged.[3]

Unprofessional conduct is defined, in part, as willful betrayal or disclosure of professional secret or the violation of a privileged communication except as required by law.[4]

Required Reports

Statute: Cases of suspected child abuse are required to be reported;[5] privilege does not apply to such reports.[6]

Special Access Laws

Statutes: Hospital and physicians records are to be made available to any patient's attorney upon written authorization of the patient.[7]

Records of the patients in the state institutions are confidential and shall not be disclosed except as the patient or guardian shall consent or a court may direct.[8]

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[1] UTAH CODE ANN. § 78-24-8(4) (1953).
[2] UTAH CODE ANN. § 58-25-9 (1963).
[3] UTAH CODE ANN. § 58-13a-36 (1963).
[4] UTAH CODE ANN. § 58-12-36 (Supp. 1971).
[5] UTAH CODE ANN. § 55-16-2 (Supp. 1971).
[6] UTAH CODE ANN’ § 55-16-5 (Supp. 1971).
[7] UTAH CODE ANN. § 78-25-25 (Supp. 1971).
[8] UTAH CODE ANN. § 64-7-50 (1968).

VERMONT

Required Reports:

Statutes: Physicians must report cases of venereal disease to the Commissioner of Health.[1] Such reports are confidential. Vermont also has various provisions requiring physicians, health officers, and other persons to report cases of certain other diseases, including communicable diseases[2] and tuberculosis.[3]

Special Access Laws:

Regulations: All information as to personal facts and circumstances obtained in connection with the administration of the Vermont State Health Department is confidential and considered privileged communications and is not to be disclosed without the consent of the individual concerned.[4] However, the regulation does not prohibit:

1) a disclosure of confidential information in summary, statistical, or other form which does not identify particular individuals, or

2) disclosure after consent by the Commissioner of such confidential information to other agencies or individuals, public or private, that are providing needed services to individuals. Only such information shall be released as is necessary to achieve the specific purposes for which the disclosure is authorized and after the individual or agency receiving such information has agreed to safeguard the confidential nature of the released information.

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[1] VT. STAT. ANN. tit. 18 § § 1092, 1093, and 1099 (1968).
[2] VT. STAT. ANN. tit. 18 § § 1001-07 (1968).
[3] VT. STAT. ANN. tit. 18 § § 1041, 1048 (Supp. 1971).
[4] Vermont Board of Health, Confidentiality Regulation, March 21, 1957.

VIRGINIA

Physician-Patient Privilege

Statute: A physician or psychologist may not testify in a civil action without the consent of the patient except when the physical or mental condition of the patient is at issue or court deems disclosure necessary to the proper administration of justice. The privilege does not apply to communications in efforts to unlawfully procure narcotic drugs.[1]

Case Law: Subpoena duces tecum for medical reports should be ordered when physical condition of the party is at issue.[2]

Required Reports

Statutes: Cases of venereal disease[3] and communicable diseases[4] are required to be reported.

Special Access Laws

Regulations: "Because of the fear of hospital personnel and physicians, patients are normally not permitted to see their medical records nor are personal representatives allowed to review or copy the records, unless litigation is undertaken.

This policy has been developed for the protection of the patient's privacy and confidentiality of the records, not fear for possible litigation."[5]

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[1] VA. CODE ANN. § 8-289 (Supp. 1971).
[2] Portsmouth v. Cilumbrello, 204 Va. 11, 129 S.E.2d 31, 33-34 (1963).
[3] VA. CODE ANN. § 32-91 (1964).
[4] VA. CODE ANN. § 32-48 (1964).
[5] Letter from John W. Crews, Assistant Attorney General, Commonwealth of Virginia, to Task Force, June 13, 1972.

WASHINGTON

Physician-Patient Privilege

Statute: A physician cannot, without patient's consent, be examined in a civil action as to information acquired in attending a patient.[1]

In criminal prosecutions physicians and surgeons are protected from testifying as to confessions or information received from any defendant by virtue of their profession and character.[2]

Psychologist-client communications enjoy the same privilege as attorney-client.[3]

Case Law: Physician-patient privilege statute is applicable to criminal cases by virtue of another statute that provides that rules of evidence in civil actions apply to criminal prosecutions.[4]

The statute which gives the privilege to physicians in criminal prosecutions has reference to the protection of the physician only.[5]

Hospital records, insofar as they tend to disclose what the physician learned, are protected by privilege.[6]

The privilege is not waived by the institution of an action for personal injuries.[7] Nor is the privilege waived by plaintiff's testimony on pre-trial deposition as an adverse witness as to the nature and extent of the alleged injury.[8]

Whenever it becomes apparent that the plaintiff must decide in favor of waiver, waiver should not be delayed until the trial itself, but defendant is entitled to know in time to take the deposition of the physician and prepare to meet his testimony.[9]

Required Reports

Statutes: Washington requires physicians to report cases of child abuse[10] and makes them immune from civil liability for such reports.[11]

Special Access Laws

Regulations: Department of Health regulations pertaining to medical records are silent as to accessibility.[12]

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[1] WASH. REV. CODE ANN. § 5.60.050 (1963).

[2] WASH. REV. CODE ANN. § 10.52.020 (1961).

[3] WASH. REV. CODE ANN. § 18.83.110 (Supp. 1971).

[4] State v. Miller, 105 Wash. 475, 178 P. 459, 460 (1919); State v. Sullivan, 160 Wash. Dec. 216, 373 P.2d 474, 479 (1962). Other states have interpreted the same two statutes to mean that the privilege is not applicable in criminal cases.

[5] 178 P. at 460.

[6] Toole v. Franklin Investment Co., 158 Wash. 696, 291 P.2d 1101, 1102 (1962).

[7] Bond v. Independent Order of Foresters, 69 Wash. 879, 421 P.2d 351, 353 (1966).

[8] 421 P.2d at 354.

[9] Phipps v. Sasser, 74 Wash.2d 439, 445 P.2d 624, 628-29 (1968).

[10] WASH. REV. CODE ANN. § 26.44.030 (Supp. 1971).

[11] WASH. REV. CODE ANN. § 26.44.060 (Supp. 1971).

[12] WASH. ADMIN. CODE § 248-18-440 (Supp. 1971).

WEST VIRGINIA

Physician-Patient Privilege

Statute: Physician is incompetent to testify without patient's consent concerning any communications made to him by his patient which were necessary to enable him to prescribe and act for the patient.[1]

Public Record Acts

Statute: When a state record is required by law to be treated in a confidential manner, its confidential nature shall be protected.[2]

Required Reports

Statute: Cases of venereal disease (without names)[3], communicable disease[4] and tuberculosis[5] are required to be reported.

Special Access Laws

Regulations: State regulations governing hospital records are silent as to accessibility.[6]

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[1] W.VA. CODE ANN. § 50-6-10 (1966).

[2] W. VA. CODE ANN. § 5-8-13 (1971).

[3] W. VA. CODE ANN. § 16-4-6 (1966).

[4] W. VA. CODE ANN. § 16-2A-5 (1966).

[5] W.VA. CODE ANN. § 26-5A-4 (1971).

[6] State Department of Health, *West Virginia Regulations and Law for Licensing Hospitals* § 601.3 (1969).

WISCONSIN

Physician-Patient Privilege

Statutes: The Wisconsin physician-patient privilege bars a physician from disclosing any information necessary to enable him to serve a patient which he may have acquired in attending the patient in a professional character. It is inapplicable, *inter alia*, in all actions against a physician for malpractice; with the express consent of the patient, or if deceased, his personal representative or the beneficiary of his insurance policy.[1]

Case Law: The Wisconsin Supreme Court has held that the statute disqualifying a physician from testifying to privileged matters is to be strictly construed.[2]

Recently, the same court narrowed the type of records that may be withheld on a claim of privilege, holding that the party claiming the privilege should not be the sole judge of what evidence is relevant.[3]

An Attorney General opinion stated that the privilege statute is for the benefit of the patient and may be waived only as provided. Also, after the death of a patient, only the privileged parts of the records may not be released.[4]

Public Record Acts

Statutes: The Wisconsin Public Record Statute[5] does not exclude hospital records, bringing up the question of whether public hospitals' records are subject to inspection.

Medical Lien Acts

Statutes: The Wisconsin hospital lien law does not provide for the inspection of hospital records.[6]

Required Reports

Statutes: Wisconsin law requires physicians to report venereal disease,[7] tuberculosis,[8] and child abuse.[9] As in most other states, child abuse reports are not privileged communications.[10]

Special Access Laws

Statutes: A Wisconsin Statute provides that a court may order the plaintiff in a personal injury or malpractice suit to give to the defendant or any physician named in the order, an inspection of x-rays and hospital records concerning the injuries for which damages are claimed.[11]

The statute also requires anyone having custody of medical records or the like to permit a person authorized by the patient or, if deceased, his personal representative or the beneficiary of a life insurance policy, to inspect and copy the records,[12] Refusal to comply can subject the person refusing access to all reasonable and necessary costs of obtaining the copies and inspection plus not more than $50 in attorney's fees. The statute is not applicable to state or county mental hospitals.
Case Law: The Wisconsin Supreme Court has held that where a prior nervous condition was in question in the suit, an order for inspection of the records of prior psychiatric treatment must be issued.[13]

Recently the same court held that the refusal of a record custodian to permit inspection on presentation of an authorization signed by the beneficiary of a deceased patient's life insurance policy would not make the hospital and the librarian liable where there was no indication on the authorization that the signer was the beneficiary or the personal representative of the deceased patient.[14]

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[1] WIS. STAT. ANN. § 885.21 (1957).

[2] Leusink v. O'Donnell, et al., 255 Wis. 627, 39 N.W.2d 675 (1949).

[3] Wilkins V. Durand, 47 Wis.2d 527, 177 N.W.2d 892 (1970).

[4] 1928 WIS. OP. ATT'Y GEN. 385.

[5] WIS. STAT. ANN. § 16.80 (1957).

[6] WIS. STAT. ANN. § 289.80 (Supp. 1972).

[7] WIS. STAT. ANN. § 143.07 (1957).

[8] WIS. STAT. ANN. § 143.06 (1957).

[9] WIS. STAT. ANN. § 48.981 (Supp. 1972).

[10] WIS. STAT. ANN. § 885.21(f) (1957).

[11] WIS. STAT. ANN. § 269.57(2) (a) (2) (Supp. 1972).

[12] WIS. STAT. ANN. § 269.57(4) (Supp. 1972).

[13] Thompsen v. Roberts, 269 Wis. 472, 69 N.W.2d 482 (1955).

[14] Fanshaw v. Medical Protective Ass'n, 52 Wis.2d 834, 190 N.W.2d 155 (1971).

WYOMING

Physician-Patient Privilege

Statute: A physician may not testify concerning a communication made to him by his patient without the patient's consent; if the patient voluntarily testifies, the patient immediately waives the privilege as to the subject matter he addressed.[1]

Communications with psychologists are also privileged.[2]
Case Law: Physicians may not testify if their patient is not a party and is not present to object.[3]

Public Record Acts

Statute: The right to public inspection is denied for medical, psychological or social data on individual persons.[4]

Required Reports

Statute: Reports are required for suspected cases of child abuse[5] to which the privilege does not apply[6]; and for cases of venereal disease[7] and communicable diseases.[8]

Special Access Laws

Regulations: Hospital and medical regulations are confidential except insofar as guardian or parent consents to release or a court orders disclosure.[9]

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[1] WYO. STAT. ANN. § 1-139(1) (1959).

[2] WYO. STAT. ANN. § 33-343.4 (Supp. 1971).

[3] Peters v. Campbell, 80 Wyo. 492, 345 P.2d 234 (1959).

[4] WYO. STAT. ANN. § 9-692.3(d)(i) (Supp. 1971).

[5] WYO. STAT. ANN. § 14-28.8 (Supp. 1971).

[6] WYO. STAT. ANN. § 14-28.12 (Supp. 1971).

[7] WYO. STAT. ANN. § 35-177 (Supp. 1971).

[8] WYO. STAT. ANN. § 35-172 (Supp. 1971).

[9] Letter from Wm. L. Kallal, Assistant Attorney General Wyoming, to the Task Force, June 15, 1972.

Appendix

GRAPHIC DISPLAY OF THE RESULTS OF STATE-BY-STATE STUDY

State	Physician-Patient Privilege	Record Acts	Hospital Lien Laws	Required Reports	Authorized Disclosure
ALABAMA	X			X	X
ALASKA	X	X			X
ARKANSAS	X	X			X
ARIZONA	X	X			X
CALIFORNIA	X	X		X	X
COLORADO	X	X	X	X	X
CONNECTICUT	X	X		X	X
DELAWARE	X			X	X
DISTRICT OF COLUMBIA	X		X		X
FLORIDA	X	X			X
GEORGIA	X	X		X	X
HAWAII	X			X	X
IDAHO	X			X	X
ILLINOIS	X		X	X	X
INDIANA	X	X	X	X	X
IOWA	X	X	X	X	
KANSAS	X			X	X
KENTUCKY	X				X
LOUISIANA	X	X			X
MAINE	X		X		X
MARYLAND	X	X	X		
MASSACHUSETTS	X		X	X	X
MICHIGAN	X			X	X
MINNESOTA	X			X	
MISSISSIPPI	X			X	X
MISSOURI	X				X
MONTANA	X			X	X
NEBRASKA	X	X		X	
NEVADA	X	X	X	X	X
NEW HAMPSHIRE	X			X	X
NEW JERSEY	X	X	X		
NEW MEXICO	X	X		X	X
NEW YORK	X			X	X
NORTH CAROLINA	X	X		X	X
NORTH DAKOTA	X	X	X	X	X
OHIO	X	X		X	X
OKLAHOMA	X	X		X	X
OREGON	X		X	X	X
PENNSYLVANIA	X			X	X
RHODE ISLAND			X	X	X
SOUTH CAROLINA	X			X	X
SOUTH DAKOTA	X	X	X	X	X
TENNESSEE	X	X			X
TEXAS			X		X
UTAH	X			X	X
VERMONT				X	X
VIRGINIA	X			X	X
WASHINGTON	X				X
WEST VIRGINIA	X	X		X	X
WISCONSIN	X	X	X		X
WYOMING	X	X		X	X

ALTERNATIVES TO LITIGATION, I: TECHNICAL ANALYSIS

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Summary

This report describes a study of the process by which alternatives to medical malpractice litigation function, and evaluates the viability of these alternatives in terms of speed, justice, cost, usefulness, and acceptability. The principal alternatives to litigation—screening panels and arbitration—are compared with each other and with the traditional action at law.

The report is divided into five sections: Section I presents introductory and background information on existing medical malpractice dispute resolution systems, including the types of screening panels and arbitration plans which exist and compares them with the action at law; Section II describes the data sources and plans selected for quantitative study, together with analytical methods and parameters used; Section III discusses the major findings; Section IV sets forth major conclusions; and Section V outlines recommendations for future research.

Major findings of the study are summarized as follows:

- In terms of classes and number of defendants, screening panels are heavily oriented toward single-defendant cases involving natural persons, such as physicians and surgeons. Actions at law (and some of the arbitration plans), on the other hand, also hear claims against corporate and institutional defendants. An inherent weakness of screening panels as an alternative to litigation is their self-imposed jurisdictional limitations.
- In terms of severity of injury, almost all of the alternative forums hear cases of about the same severity distribution (kind and number) as do actions at law. Three significant findings emerged from the analysis of the Ross-Loos Medical Group arbitration plan—it disposed of cases overwhelmingly by informal settlement rather than arbitration; tended to involve cases of less severity than other forums; and claims settled without legal representation were settled for less than half the amounts awarded to claimants represented by attorneys for cases of comparable severity. The Maryland physician screening panel differed from other screening panels by hearing a higher percentage of more severe claims. The reason for this perhaps lies in the purpose of the physician screening panel, which is to determine whether to settle or contest claims rather than adjudicate them on their merits, and in the fact that physician screening panels are administered in conjunction with the physicians' liability insurance carrier and its counsel, who in large measure determine which claims are heard by the panel.
- In terms of the kind of malpractice allegation considered by the alternatives to litigation and actions at law, all of them heard about the same ratio of failure-to-diagnose to improper-treatment, the two primary classifications of negligence. The one exception was the Pima County (Arizona) medical-legal screening panel, which heard a far higher proportion of failure-to-diagnose claims than did any other alternative forum. Although this finding lends credibility to the criticism that the existence of an inexpensive claims resolution forum tends to increase the number of claims, almost all allegations of improper diagnosis were dismissed by the panel.
- In terms of decision ratios (the number of decisions for the plaintiff divided by the total number of decisions) computed for one representative of each kind of plan, it was determined that all of the plans find for the claimant about the same percentage of the time. However, when the screening panel is composed solely of physicians, the decision ratio, although not of statistical significance, is far more heavily weighted in favor of the physician. Of further interest, the physician screening panel tends to decide in favor of the claimant more frequently as the severity of the case increases. Decision making of the

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medical-legal panel was not found unfairly weighted or biased in favor of the physician. In general, the medical-legal screening panel and the court-sponsored screening panel find as frequently for the claimant as does the action at law, and in one plan more frequently.

- In terms of speed and administrative efficiency of all plans from which data was gathered, case data analyzed rebutted the contention by the insurance industry that there is inherent unfairness in the rule of law which provides that the statute of limitations begins to run from discovery of the injury rather than from the date of the negligent act which produced the injury. The delay lies in other factors inherent in the resolution process. Attorneys tend to wait until the statute of limitations is about to expire before filing an action at law. The time from formal filing to hearing, however, for the alternatives to litigation is far shorter than for actions at law. Although none of the alternative forums dealt with claims with the dispatch which their published rules indicate, the average time from filing to hearing was six months for a screening panel, compared to approximately 18 months for an action at law in similar jurisdictions.
- In terms of professional attitudes toward alternatives to litigation, most physicians and attorneys view the procedures in their own jurisdictions favorably.
- In terms of impact on the docket loads of courts, it appears that physician screening panels may reduce docket loads by only 3.4% of the total volume of medical malpractice claims; that medical-legal screening panels reduce claims by approximately 24.5%; and that court-sponsored screening panels (based on the only plan with significant operating experience) reduced the docket load by about 6.0%; and arbitration by 0.7%.
- In terms of costs (evaluated in three severity ranges) physician screening panels appear to be the least expensive, followed in order by medical-legal screening panels, arbitration, court-sponsored screening panels, and actions at law.
- The detailed case disposition by one jurisdiction which did not have a screening panel, compared with another which did, indicated that the summary judgment procedure has been widely under-emphasized as an important factor in the resolution of litigated claims.
- Of the many plans studied, only one uses the knowledge gained to improve the quality of medical care. Neglect of this possible benefit is also apparent in actions at law.
- Although arbitration has been widely publicized as an alternative to litigation, data from the only plan to accumulate operating experience indicates that only 5.1% (three cases) of the claims were actually subjected to the arbitral process.
- This report concludes that the medical-legal screening panel has the highest potential for success, but that it must be recognized statutorily to overcome its jurisdictional limitations.
- Only a small fraction of medical malpractice claims is submitted to the alternative forums. It is estimated that claims against physicians could be reduced by 75% through these forums of dispute resolution, and that cases actually leading to the litigation process could probably be reduced by as much as 50%.

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Section I
Introduction

A. BACKGROUND–MEDICAL MALPRACTICE DISPUTE-RESOLUTION SYSTEMS

Great effort, time, and attention have been devoted to the creation of alternatives to litigation, for there are many individuals who believe there are serious functional and social flaws in resolving medical malpractice disputes through the traditional submission to trial by jury. This section of this report on a study of alternatives to litigation in medical malpractice disputes compares the major attributes of the action at law and existing alternatives to it as they are employed in the resolution of such disputes.

Objectives of Dispute-Resolution Systems

The objectives of systems to resolve disputes between parties, whether judicial, administrative, or contractual, have never been better stated than to provide a "just, speedy, and inexpensive determination" of the controversy.[1] These objectives, as related particularly to medical malpractice disputes, and some considerations relevant to society at large, are discussed in the paragraphs which follow.

Substantial Justice

An ideal system for the resolution of malpractice claims should provide substantial justice to the parties. A large percentage of the total damages awarded should go to the injured party rather than be absorbed by the dispute-resolution system and its practitioners. Awards should be made similar for similar injuries. A legitimate claimant should be aided willingly by the medical profession in proving his case. The bar should be deterred from bringing frivolous claims against innocent physicians. Finally, the amount of money awarded as damages should be based only on legal fault and the damages flowing consequently from it; and the issue of sympathy for the claimant injured without legal fault should not influence the determination of liability.

Rapid Determination

Malpractice litigation, for special reasons, requires a quick determination of the ultimate liability of the parties. By a rapid resolution of controversies, minimum embarrassment and potential damage to the professional reputation of the falsely-accused physician will occur. The injured claimant will undergo a short waiting time for his just compensation, and the malpractice insurer will be aided in planning with greater actuarial certainty his undertaking to insure.

Inexpensive Procedure

An ideal mechanism for the resolution of malpractice claims should be inexpensive. By aiming at perfection, the traditional judicial trial by jury, with its complicated fact issues, high preparation costs, and lengthy trials, is necessarily expensive. The maxim "the law does not concern itself with trifles" is an economic fact, for the expense incurred in the resolution of small claims by the traditional action at law is greater than their value.

Useful and Beneficial Purpose

A medical malpractice dispute is an indication that the practice of medicine has fallen below the tolerable minimum standard of quality, as perceived by the patient. This perception includes not only the technical attributes of the applied science or art of healing, but the interpersonal relationship between patient and physician. When a verdict is awarded by a jury in favor of a claimant, it is an indication that society and the system of laws that regulate it agree.

When a dispute occurs, an ideal resolution mechanism should seek (in addition to resolving the dispute) to examine dispassionately and objectively in a controlled, organized way this breakdown in harmony among science, art, interpersonal relationships, and societal expectation. The purpose of such an examination should be to improve, educate, and prevent future breakdowns of like kind and tenor. It is perhaps in this singular regard–the improvement of the quality of medical care–that the present jury trial system only clumsily serves the needs of society; and this study raises doubts whether the existing alternatives to it would improve this dimension.

Acceptability

Any improvement, however, to the current judicial trial method of resolving controversies should ideally be acceptable to the parties concerned and strike a fair balance among their naturally competing interests and the interests of society, which is advantageous to all. Above all else, a voluntary alternative must be more attractive to the claimant than an action at law. It is assumed in this report that alternatives to litigation will be voluntarily pursued. This assumption will hold true unless some non-voluntary repressive mechanism is adopted by changes to existing laws to deny a party his "day in court." Although this position, in practical effect, has been advanced by some spokesmen for organized medicine, there are valid policy

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[1] Rule 1, Federal Rules of Civil Procedure

reasons why it cannot be done for the benefit of a privileged segment of society, however important.

External Influences

Economic Motivations

Physicians and hospitals—insured by a professional liability insurance carrier—seek to minimize their insurance costs if they wish to maximize financial rewards or achieve benevolent purposes in the face of mounting public concern over the increasing cost of medical care. The insurance carrier seeks to earn a reasonable profit for the risks which it assumes and, if at all possible, to avoid loss. Professionals within the legal system—attorneys for claimants and defendants—also seek to maximize their financial rewards. The press and media are motivated toward reporting the scandalous and bizarre to increase circulation and profit. And patients may be tempted, perhaps frequently, to assert nonmeritorious claims to secure unjust riches.

The medical malpractice claims arena is a fruitful segment of dispute resolution in which economic motivations may lead to abuses. Many of the more widely promoted alternatives to litigation analyzed in this report stem, admittedly, from the self-serving economic motivations organized medicine and its captor and captive—the professional liability insurance industry. To the extent that their economic objectives can be achieved without detriment to the consumer or drastic imbalance favoring any special segment, they perhaps represent valid societal objectives.

Professional Sophistication—and Sensitivity

The stature of the physician in society (along with many other institutions) is widely reported as eroding. Physicians view judgment of their medical acts by laymen, however intelligent or impartial, as unfair and unjust. From the perspective of a physician defendant, the trial by jury—even when aided by expert witnesses—has been reported as a poor and unfair way to assess the merits of his practice.

Public Awareness and Resort to the Courts

The current age of "consumerism", founded initially on widespread dissatisfaction with the quality of products, has reached to question critically the performance and value of virtually every institution in society. Americans are now less passive in their acceptance of things. Much of this unrest has resulted in greater redress to the courts where, for some elements of social change, response has been more immediate and satisfactory than from legislatures or the executive.

These form the backdrop against which the pursuit of medical malpractice claims is enacted and it is the purpose of this report to evaluate the existing alternatives to litigation and the litigation process to determine the extent to which the stated objectives are achieved. Where specific technical findings can cast light upon these considerations or where findings are reflective of these deeper meanings, they are addressed in this report.

B. AN OVERVIEW OF EXISTING MEDICAL MALPRACTICE DISPUTE-RESOLUTION SYSTEMS

Definition and Explanation

The principal forms of formal dispute-resolution systems analyzed in this report are actions at law and alternatives to litigation—screening panels and arbitration. The overwhelming majority of disputes is settled informally; but the formal system influences and shapes the informal; and the informal, the formal. So both must be analyzed together.

Alternatives to the action at law are defined as:

- *Screening Panel.* In this study, the term "screening panel" will include a wide variety of administrative adjuncts to the judicial process which is designed to permit early settlement of meritorious claims and discourage frivolous litigation. Screening panels have as their main objective the settlement by the insurer of an allegation of malpractice based on substantial merit, without the necessity for the claimant to proceed to an action at law.
- *Arbitration.* In this study, the term "arbitration" will include procedures arising out of a contract between a medical entity and the patient, which includes an agreement to submit resolution of disputes arising from treatment to complete and final nonjudicial settlement. Arbitration, therefore, is a complete substitute for an action at law, in which the issues of blame-worthiness, causation, and damages are determined.

This careful distinction between arbitration and screening panels is necessary for rational analysis. Widespread use of the terminology in the literature squares with the definitions selected. It is recognized that this distinction is in contrast to that used in a widely circulated article, "Should Medical Malpractice Claims Be Arbitrated?" by Robert Coulson,[2] who would include both systems under the term "arbitration" and then distinguish only on the basis of procedural formality. Argument has been advanced that there is a basis in legal theory for this characterization because the scope of the arbitral agreement can be as narrow or as broad as the parties make it. In common practice, however, all issues of the subject matter of a controversy are usually embraced in order to secure the desired effect of finality and res judicata.[3]

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[2] Robert Coulson, "Should Medical Malpractice Claims Be Arbitrated," American Arbitration Association (October 28, 1970).

[3] See, M. Domke, *The Law and Practice of Commercial Arbitration,* sections 24.01-24.06 (1968), and Winikoff, "Medical-Legal Screening Panels as an Alternative Approach to Medical Malpractice Claims", 13 Wm & Mary L. Rev. 693 (1972).

Table 1 provides a summary explanation of malpractice claim settlement modes. The three forums where a claim may be decided are contrasted in the table to show:

- Their essential initial element; that is, what must exist in order to have the forum available for the total or threshold resolution of a malpractice claim.
- The event to make the forum operative; that is, what must be done by a party seeking to avail himself of the forum to start the process in motion.
- The name of the decision-making body.
- The possible findings.
- The stated major objective of the particular forum.

Operation

Informal Investigation Phase

Flowing from an incident in which medical malpractice may have occurred, an informal investigation phase is initiated. In all cases, the initiation process consists of interviewing potential witnesses and attempting to determine what in fact happened, in order to evaluate the validity of the claim from the perspective of the law. Although under the rules of legal procedure in most jurisdictions, it is possible to institute the taking of depositions (sworn statements under oath in answer to verbal questions by the attorney) prior to the filing of an action at law, even this activity must be preceded by the informal investigation phase. There is little difference, therefore, in how this informal investigation phase is conducted, irrespective of the dispute-resolution method initially or ultimately adopted.

Formal Claim Initiation Phase

Once the claims initiation process enters the formal phase, the action at law becomes technically complex. Writings are exchanged between the adverse parties, and the potential arises for a multiplicity of parties to be joined. Claims may be made by the defendant against the plaintiff in the nature of a counterclaim, and cross claims made between parties aligned on the same side. What is important is that these pleadings in an action at law are highly formal, technical, stylized legal documents. They are not only expensive to prepare, but are fraught with difficulty in accurately substantiating the theory of the lawsuit and assuring that a valid legal theory has, in fact, been adopted. Although the early common law rules of strict pleading have largely been abandoned in the vast majority of American jurisdictions through the allowance and encouragement of what has been called "fact pleading", the allegations of fact must nevertheless substantiate an adequate legal theory upon which a claim or defense may be based.

Some characteristics of the way in which this process takes place in the initiation phase of an action at law and in the major alternatives to litigation are shown in Table 2, and their importance is discussed in the paragraphs which follow.

In formality of pleadings, the alternatives to litigation abandon the stylized formality of an action at law by requiring only a short informal statement of facts, generally through a simple letter from the patient's attorney and, most frequently, a simple letter from the physician or his attorney in reply.

It is to be noted that, during the initiation phase, the purpose of the action at law—to resolve with finality all claims against all parties arising out of a single incident—is sharply abandoned by the alternatives to litigation processes. Their jurisdiction over parties and subject matter is very limited. The jurisdiction of screening panels is generally limited to members of a medical society who have reached a joint agreement with the local bar association providing for the establishment of the screening panel. The jurisdiction of screening panels, in most instances, is voluntary or consensual. In arbitration, formal jurisdiction is limited to the parties to the contract, generally the patient and medical entity.

After formal or informal pleadings have started the dispute-resolution process, there is even more difference in the complexity of the alternatives to litigation and the action at law. For example, during an action at law, a variety of preliminary motions may be made upon the pleadings, such as motions for more definite statements of fact in order than an adequate answer can be prepared; motions to strike redundant, immaterial, scandalous, or impertinent materials, or defenses insufficient at law; and motions raising defenses which, for the purposes of the most widely modeled rules of civil procedure (those employed by the federal court system in America), allow six defenses to be raised preliminarily by motion. In addition, at the conclusion of the formal pleading stage in an action at law, either party may move for judgment on the pleadings alone or for summary judgment, which considers material raised by both parties in their pleadings and such additional affidavits and factual material as may be permitted under the rules. All of these preliminary motions, in addition to their requirement for being in writing, generally require extensive supporting legal memoranda and briefs of points and authorities in their support, and court time for consideration and disposition.

By contrast, the alternatives to litigation abandon completely this time-consuming, expensive, written process which, in many civil lawsuits, may be abused for the purpose of gaining time while facts are gathered and evaluated to support the preliminary framing of an adequate defense.

None of the alternative procedures studied embodied any of the facets found in the preliminary motions in the traditional action at law. In one sense, this may be a weakness. There is great merit, for example, in understanding clearly the exact claim which the plaintiff is making, and the motion for a more definite statement (if used in good faith and not for harassment and delay) does provide a sharpening of the issues for their later disposition.

TABLE 1
SUMMARY EXPLANATION OF MALPRACTICE DISPUTE RESOLUTION SYSTEMS

Forum	Essential Initial Element	Event to Make Operative	Decision-making Body	Possible Findings	Objective
Arbitration	Contract between medical entity and patient	(Contractually) claim by either party (Universally) claim by patient and demand for arbitration	Arbitrators	Liability *and* Damages	Determine with finality
Screening Panels	Procedure established by medical entity (and most frequently) with bar association, by statute or rule of court	Claim by patient (or sometimes) Report by physician or by statutory or court rule procedure	Screening Panel (or by variety of formal names associated with each such plan)	Possible/probable "Negligence" (and frequently) whether possibly/probably caused harm OR "Settle" or "Contest"	Threshold Determination: Abandon, settle, or contest
Actions at Law	Jurisdiction of the parties and the subject matter	Filing a complaint or declaration by the patient	Court 1. Judge 2. Jury (most frequently included)	Liability *and* Damages	Determine with finality

TABLE 2
COMPARISON OF MALPRACTICE DISPUTE RESOLUTION SYSTEMS—INITIATION PHASE

Forum	Formality of Pleadings	Multiplicity of Parties	Multiplicity of Claims	Opportunity for Preliminary Motions
Arbitration	Informal—factual statement supporting legal theory.	Limited by arbitral agreement. Generally narrow.	Limited by arbitral agreement and in some jurisdictions by law. Counterclaims permissable.	Seldom used
Screening Panels	Highly informal—short statement of facts by the patient's attorney and a simple letter in response by the physician or his attorney.	Generally limited by membership in medical society. Court rule and statutory plans deal effectively or exclusively with physicians only.	Limited by rules. The majority of plans deal only with two elements of the tort of negligence, breach of duty, and causation. No counterclaims.	Rarely used
Actions at Law	Formal—the trend is away from formality but the facts to sustain a legal theory must always be alleged.	Generally unlimited if service of process can be achieved.	Generally unlimited. A few jurisdictions still prohibit joinder of claims in tort and contract.	Extensively used imaginatively used for their stated purpose and tactically for delay.

Case Preparation Phase

It is perhaps during the preparation phase that the action at law, with its formal stylized rules of "discovery", contrasts most strikingly to the alternatives to litigation. Table 3 outlines and compares these differing characteristics, which are amplified in the following discussion.

In an action at law, many elements of formal discovery are available under the process of the court—extensive depositions taken from parties and witnesses; written questions addressed to parties; the discovery and production of documents and things for inspection, copying, and photographing; physical and mental examinations of persons; admission of facts and genuineness of documents; and other elements—all of which have as their purpose the enhancement of the fact finding process and focusing on the issues in dispute. This formal discovery process in the action at law is extensively used in the litigation of medical malpractice claims. Hospital records are subpoenaed, and interrogatories and depositions are addressed to physicians and hospital personnel.

In addition to their primary purpose, these "rules of discovery" are designed to allow motions to be made for summary judgment, given that proper facts are admitted. A further complexity in an action at law is that failure to comply with discovery procedures brings on motions through which the court is asked to direct compliance or, conversely, motions seeking protective orders through which parties seek to avoid discovery by labeling it undue harassment.

In contrast to this case preparation phase of an action at law, with its elaborate machinery for discovery, the alternatives to litigation are markedly simple. For example, without subpoena or process of a court, hospital and medical records are freely made available to panel members. One medical society has the unique practice of providing an expert witness prior to the alternative to litigation hearing phase, without cost to the claimant, to allow his attorney to ascertain the particular merits of the claim. This process, conducted as a nonadversary proceeding, could be prejudicial to the right of a potential plaintiff if the expert medical witness views his role as one of compromising or ameliorating an adverse claim against a fellow member of the medical society. However, this instance probably provides the greatest incentive for the use of the alternative process because the claimant is spared the significant expense of providing his own expert advice inherent in an action at law.

The prehearing phase, or "pretrial" as it is called in the action at law, is designed to focus and sharpen the issues; to give parties an opportunity to amend pleadings which may have been overcome by events or material discovered since filing of the lawsuit; to eliminate unnecessary proof by securing from the parties admissions of facts and genuineness of documents; to apprise the court and opposing counsel of the purpose for which witnesses are being called; to limit the number of witnesses only to those essential to prove the claim or defense; to eliminate redundancy in testimony; and a host of other matters.

One matter to which the Federal Rules of Civil Procedure lend themselves is the court's consideration of the advisability of referring a complex issue of technical fact to a master, for him to make a finding to be used as evidence at the trial. In this context, medical malpractice

TABLE 3

COMPARISON OF DISPUTE RESOLUTION SYSTEMS—CASE PREPARATION PHASE

Forum	Formality and Complexity of Discovery—Subpoena Power	Availability of Medical Records	Expert Medical Advice to Claimant	Prehearing Procedure
Arbitration	Similar to actions at law with some tendency toward informality. Thorough.	Through subpoena.	Provides own.	Generally none, or accomplished informally by the parties.
Screening Panels	Highly informal, often non-adversarial, and of questionable thoroughness.	Voluntarily provided in most plans.	Sometimes provided free by medical society to claimant.	Embodied in the rules of some plans, but rarely used.
Actions at Law	Highly formal, expensive complex, adversarial, time consuming, painstakingly thorough, and burdensome to answering party.	Through subpoena.	Provides own.	Rules exist in almost all jurisdictions. Effectiveness varies greatly with local custom and active participation of judges.

disputes at trial could be simplified by the use of an expert from a panel of physicians to assist the frequently mentioned inability of lay juries to comprehend the conflicting and complex issues of technical fact needed to define and prove the standard of medical care, its breach, and the factual elements of causation as they constitute the medical issues in the trial. It is at this point, however, that the formal trial process in an action at law most clearly assumes its adversary character—counsel for both sides are insistent upon putting to the jury these complex issues of medical fact, often through days of lengthy testimony and cross examination. In addition, each side invariably presents expert witnesses who have conflicting views on the fundamental medical elements of the case, which must then be weighed and resolved by the unsophisticated lay jury.

By contrast, in the alternatives to litigation, the prehearing phase is most frequently entirely omitted and, if conducted, is generally highly informal.

Case Hearing Phase

Table 4 summarizes contrasting characteristics of the action at law and alternatives during the case hearing phase. During the trial at an action at law, evidence is presented to unsophisticated fact finders in the jury of laymen, only in accordance with complex rules designed by trial and error throughout the centuries of our common law heritage to ensure that evidence reaches juries in only its most reliable form. By contrast, the hearing phases of screening panels and arbitration proceedings are highly informal since the fact finders are composed of medical or legal experts who supposedly do not require the "protection" from unreliable evidence required for a jury of laymen. Therefore, the formal technical rules of evidence, which have as their purpose the exclusion of unreliable evidence, may be completely avoided or limited to those which require consideration of only relevant and material matters.

In addition, without exception, the hearing in the alternative forums is conducted privately. This is in sharp contrast to the public trial of an action at law. Here, too, abandoning the public trial introduces countervailing considerations of public interest. For example, if an action has been committed by a medical entity giving rise to an action for damages at law, our theory of litigation holds that free and public disclosure be made thereby to all interested persons. There is a danger in widespread use of the alternatives to litigation that their privacy may be self-defeating in terms of any community consciousness of the quality of medical care which would be disclosed through a public trial of the issues. By contrast, physicians find screening panels, and especially those composed solely of physicians, to be groups of qualified peers able to judge the merits of their work. Findings of other physicians are generally considered by physicians to be fairer and easier to accept than those rendered by the lay jury.

Closely related to privacy of the hearing is the question of making a transcript of the proceedings. The general practice at an action at law is to require a transcript; and for an important trial, the making of a transcript of every work spoken is considered an essential preservation of the proceeding (should prejudicial conduct occur), thus preserving the right to appeal through the use of the written record.

In arbitration proceedings, no jurisdiction with a general arbitration statute requires that a transcript of the hearings be kept. However, in the majority of jurisdictions, the presence of a reporter may be made a condition precedent to performance of the arbitration agreement, although the subject is not specifically excluded from or included in the arbitration statute. In sharp contrast is the practice before screening panels. These tribunals expressly prohibit the making of any record and require that their testimony be taken in secret. A few jurisdictions have recognized, under a policy of the law which encourages settlement negotiations, the privileged character of testimony before screening panels.

Generally, in an action at law testimony is given under oath as a matter of right to ensure that answers to questions are carefully considered and the inherent solemnity of the proceedings preserved. In arbitration proceedings, oaths are specifically required by statute in only five jurisdictions; however, judicial support for the oath has been given in a few others. In general practice, however, the requirement for testimony under oath is waived in most arbitration hearings. Screening panels rarely mention the requirement for sworn testimony in their plan rules or require that testimony be given under oath.

In a trial of a civil action at law, cross examination is always permitted. However, it is generally limited to any material matter raised in direct examination of the witness. Wide latitude is generally given, as attorneys regard this device a valuable tool in deriving the truth. Cross examination may be demanded in most jurisdictions during arbitration hearings, although wide discretion is given to the arbitrator as to how it is conducted. By contrast, screening panels severely proscribe the right of cross examination. In those screening panels in which the parties present their cases to the screening panel outside of the presence of the opposing party, there is obviously no opportunity for cross examination. In screening panels which preserve some remnants of an adversary proceeding, limited cross examination is permitted, but the plan rules frequently mention that it be dignified, polite, and inoffensive to the physician.

The power to subpoena witnesses to a hearing is broadly granted by courts in the trial of an action at law. Similarly, statutes or judicial construction in most jurisdictions give to arbitrators the power to subpoena witnesses either directly or through the court. In general, however, screening panels are not given any subpoena power.

Case Disposition Phase

Table 5 compares facets of the disposition phase of the action at law and of the alternatives to litigation.

TABLE 4
COMPARISON OF DISPUTE RESOLUTION SYSTEMS—CASE HEARING PHASE

Forum	Observance of Rules of Evidence	Privacy of Hearing and Confrontation of Adverse Party	Transcript of Proceedings	Requirement for Testimony Under Oath	Right and Scope of Cross Examination	Power To Subpoena Witnesses
Arbitration	Wide discretion arbitrator. Hearsay widely permitted. Some jurisdictions require that evidence tending to undermine fairness be excluded.	Private; both parties always present.	Not required. Generally parties may bring a reporter at their expense, as a condition of the hearing.	May be demanded in many jurisdictions. Specifically required by statute in 5; elsewhere judicially required. Most frequently waived.	May be demanded in most jurisdictions.	Afforded in most jurisdictions. To arbitrator or through court.
Screening Panels	A few plans limit to "relevant and material". Generally affirmatively abondoned by plan rules.	Private: both parties not always present in some plans.	Expressly prohibited by most plans. Proceedings are privileged in some jurisdictions.	Rarely mentioned in plan rules or required.	Seldom permitted. Must be "dignified and polite" where permitted.	Generally none.
Actions at Law	Carefully designed to ensure that only the most reliable evidence is heard by the jury. Complex, and fraught with grounds for error and appeal.	Public; confrontation. Witnesses generally excluded unless testifying. Scandalous or shocking testimony may be heard with public excluded.	Generally required and made.	Always, as a matter of right, to ensure that testimony is carefully considered and solemnly given.	Always permitted. Generally limited to any material matter raised in direct examination. Wide latitude generally given to derive truth.	Broad power.

TABLE 5
COMPARISON OF DISPUTE RESOLUTION SYSTEMS—DISPOSITION PHASE

Forum	Finality	Enforcement	Appeal
Arbitration	Awards are final and binding and res judicata in the majority of jurisdictions.	Docketing or entry in court of general jurisdiction. Then enforced as a judgment.	Very limited. No hearing de novo if arbitrator has rendered a decision on the merits.
Screening Panels	Seldom final. Some plans secure agreement from claimant to drop claim if finding is for the physician.	Limited. Good faith of claimant's attorney. Professional sanctions on claimant's attorney.	Hearings frequently are followed by actions at law.
Actions at Law	Verdicts and judgments are are final and res judicata, subject only to appeal.	Execution and levy.	Review is by appellate tribunal. New trial may be granted if appellant is successful. Frequently obtain finality on appeal.

In an action at law, the complete disposition of the controversy is reached through a finding of liability, the quantum of money damages, and their rendering in a verdict by the jury. Judgment is then imposed upon the verdict by the court, usually after consideration of motions for judgment notwithstanding verdict and motions to set aside the verdict. Upon judgment, a host of post-trial motions is available—typically for a new trial, additur, or remittitur damna (adjustment of the jury's verdict if money awarded is too low or too high in the discretion of the court, which has the discretion to grant a new trial if the adjustment is not accepted)—all framing the ground for an appeal.

By contrast, the screening panels are mainly limited to their purpose of securing and influencing subsequent settlement by the parties. These alternative forums to an action at law usually limit their findings to whether or not there was a breach of professional duty and whether that breach of duty, if found, was the factual and legal cause of the claimant's injury. The only alternative forum in which money damages are determined and awarded is arbitration.

In actions at law, verdicts and judgments are final, binding, and res judicata (subject only to appeal) in all courts of general jurisdiction in America. By contrast, arbitrators' awards are final and binding in 47 of 48 jurisdictions where a general arbitration statute has been enacted; only in Hawaii is this vital question apparently unclear. Decisions of screening panels are seldom final, for their purpose is to encourage settlement. Some plans, however, secure an agreement from the claimant whereby his claim will be abandoned if the panel renders its finding for the physician. In a few jurisdictions, this agreement is enforced contractually, but the majority of screening panels also imposes upon the claimant's attorney an obligation to drop the claim unless, in the greatest professional good faith, he believes it in the best interests of his client to pursue the claim further.

Enforcement of judgments resulting from an action at law are by execution and levy through the writ of fieri facias (or its modern equivalent) through which property of the defendant may be seized and sold in satisfaction of the plaintiff's judgment. Awards of arbitrators are enforced by entry or docketing in a court of general jurisdiction whereupon they are generally enforced in the same manner as are judgments emanating from a court of law.

Appeal from actions at law is to a court of superior jurisdiction. The appellate tribunal may grant a new trial if the appellant is successful on appeal. However, numerous cases can be determined with finality upon the disposition of an appeal. Although limited grounds for judicial review are specified in the statutes of the 48 jurisdictions where general arbitration statutes have been enacted, Alabama, Delaware, and South Carolina have statutes which are silent on the point, but case law has established guidelines and standards for judicial review. This does not suggest that the courts may hear the matter de novo or grant a complete evidenciary hearing of the subject matter arbitrated. Forty-five jurisdictions expressly prohibit de novo hearings of a controversy submitted to arbitration on which an award has been made. By contrast, screening panel hearings frequently are followed by actions at law (and conceivably a screening panel hearing could be followed by arbitration of the controversy, although no instance of this practice was encountered).

Little guidance is given to the parties by screening panels in performing their main objective of achieving settlement. If a finding of a breach of professional duty and a causal link to the claimant's injury is rendered by the screening panel, this fact (in the majority of plans) is made known to the parties and the incentive for settlement provided. If no settlement is reached, the plaintiff has the medical society's guarantee of expert witnesses at trial. In those jurisdictions where there is a strict locality rule as well as a tight knit community of interest among physicians (or "conspiracy of silence", depending on whether the relationship is viewed from the perspective of physician or lawyer), this guarantee of an expert witness at the trial has a range of attractiveness from desirable to almost essential to the plaintiff.

Conclusions

This then is a brief overview of the procedural attributes of an action at law compared to the majority of arbitration plans and screening panels. These attributes will be analyzed more thoroughly in subsequent sections of this report because there are many kinds of screening panels and, depending on their purpose, they may function with variations not described in this brief introductory section.

Although the action at law determines the merits of a claim publicly and with a high degree of finality against all parties, while reportedly reflecting society's views on the controversy through the jury system, it does so at an enormous price in terms of professional manhours. The procedure is expensive, not only from the amount of attorney time to evaluate the claim and prepare the voluminous documentation, interview witnesses, and prepare for trial, but physicians also must spend a great deal of time in preparing their expert medical testimony for the trial. Those physicians who are defendants must answer extensive interrogatories, be available for the taking of their sworn testimony out of court through depositions, undergo a lengthy trial, and during trial, endure a rigorous and often scathing cross examination and public exposure of the entire matter before the court.

By contrast, the alternatives to litigation seek to simplify the entire process and reduce it to those elements necessary for an essential determination of the merits of the claim.

As to their ultimate potential for widespread use, both alternative systems have some limitations. If arbitration were to become widely used in the resolution of medical malpractice claims, the availability of a body of expertise for this sophisticated fact finding must be questioned. Screening panels, by contrast, have a higher probability of providing both medical and legal expertise but suffer from the lack of finality and perhaps might not provide the degree of impartiality afforded by the jury or the time-tested adversary process found in an action at law.

Whether any of these processes renders justice in its pure sense is a point which cannot be determined with finality. Obviously, there is the opportunity for justice and injustice in all dispute-resolution systems, including the action at law. It is a conclusion of this report, however, that a greater opportunity for abuse of the plaintiff's legal rights probably exists within the alternatives to litigation than in the trial at an action at law. The basis for this conclusion is that in the action at law, both sides of the controversy are represented to the fullest extent of the competence of their representatives; severe penalties are imposed by society should any untruths be introduced deliberately into the proceedings; and while the lay jury may not fully comprehend the technical matters, they reflect the attitudes of the community which all professions seek to serve. By contrast, the alternatives to litigation introduce the possibility that a close knit community of physicians and attorneys might work an injustice against the interests of the claimant in their private determination of a controversy.

There are many paths by which a medical malpractice claim may be resolved. Figure 1 displays these interactions among claims resolution mechanisms. The figure teaches that if the alternative to action at law is to be used and adopted, it must interact with the formal litigation process to provide a balance of benefits and detriments to the participants carefully framed to make the alternative path more attractive than the existing judicial mechanism. As the figure illustrates, even though screening panels, arbitration boards, and other resolution mechanisms exist, the threat of an action at law is always present. This is because if settlement has not been reached at any time during or before the proceedings, any of these alternative mechanisms may be abandoned (either with ease or with difficulty, depending on their form of initiation) and an action at law pursued.

In the analytical section of this report, the way these various alternatives to litigation have interacted with the litigation process will be analyzed. It is significant to note, as will be discussed in the section which follows, that screening panels may be involved in the resolution process either before or after the filing of a lawsuit and therefore may represent an attempt to seek the advantages of both by the claimant. Court-sponsored screening panels necessarily exist within the judicial framework and some physicians' screening panels are brought into activity only by the existence of an action at law.

C. DESCRIPTIONS OF EXISTING ALTERNATIVES TO LITIGATION

Screening Panels—Existing Plans

There are many types of screening panels. They are formed sometimes by physicians alone, but more often by physicians in association with attorneys. Those studied also include two plans which are sponsored and administered by court systems. In addition, there is one statutory plan. The overriding uniform feature of these screening panels is that none of them determines the merits of the claim with finality as would arbitration or an action at law. All of them, to varying degrees, share the common goal of encouraging or requiring settlement of meritorious claims and the abandonment of claims which, in the opinion of the panel, are not supported by sufficient evidence of professional negligence to merit bringing an action at law.

All of the medical-legal screening panels seek to encourage their use by providing to the claimant an expert witness in any later trial at an action at law if the panel finds in his favor. In addition, agreements between the medical societies and bar associations seek through the plane of locally defined professional ethics to require the claimant's attorney to first present his case to the panel before bringing an action at law, and to abandon the claim, either voluntarily or by prior agreement to do so, if the finding favors the physician.

Not included in this study are the many panels of medical experts set up to provide impartial medical testimony in personal injury cases. These panels generally consist of groups of physicians who have signified a willingness to be retained privately for the purpose of studying and advising claimants about their cases. If members of these expert witness and advisory panels consider a case to have substantial merit, they will appear as witnesses if it goes to trial.[4] Although these expert witness panels may act as a screening device for medical malpractice claims (should their advice to the claimant's attorney indicate that no valid claim exists) neither their institutional cohesiveness nor organized behavior is susceptible to rigorous study.

In the sections which follow, the form and function of the five major types of screening panels are discussed summarily. A later section of this report analyzes in detail from the perspective of the procedural attributes of an action at law the rules of each of these types of screening panels compared to each other and to arbitration. The five major types of plans discussed in this section are:

- Physician Screening Panels
- Physician-and-Advisory Screening Panels
- Medical-Legal Screening Panels
- Court-Sponsored Screening Panels
- Statutory Plan

Physician Screening Panels

The six plans studied which fell in this category have as their central objective the control and regulation (to some degree) of the medical liability insurance program within the jurisdiction. Five of them operate as state plans and one is a county plan. There are undoubtedly numerous other such plans whose existence was not publicized.[5] All of them share the ingredient of providing a decision-making body composed entirely of physicians. The claimant does not appear before these screening panels and present his case. Generally, the claimant's case is presented to the panel of physicians by an attorney retained by the medical society or by an administrative employee of the medical society.

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[4] See Sadusk, "Expert Witness and Advisory Panels," 168 *J.A.M.A.* 2121 (1958); D. Louisell and H. Williams, *Medical Malpractice,* New York, Matthew Bender & Co., Inc., Section 7.02 (1972 Supp.), and Note, "The California Malpractice Controversy," 9 Stan. L. Rev. 731 at 744-6 (1957).

The major purpose of these physician screening panels is to determine whether a claim alleging medical malpractice should be settled or defended. Such plans tend to operate in secrecy, keep few records, and, in general, were reluctant to cooperate with the detailed analytical portion of this study by making case records available. One exception, however, was the Medical Chirurgical Faculty of Maryland, which provided extensive records of malpractice actions in that state as well as records of its screening panel decisions so that this category of screening panel could be included in the quantitative study, discussed later in this report. From the limited determination which could be made upon inquiry, it appears that the Med–Chi Faculty of Maryland is the only physician screening panel which has comprehensively assessed the medical malpractice problem within its jurisdiction in a constructive and objective manner. The other panels could be characterized as stemming solely from the self-serving interest of the physicians who compose their membership.[6] Correspondence and fragmentary data provided by some physician screening panels indicated a far greater interest in defending a claim than investigating its merits.

Physician-and-Advisory Screening Panels

Two plans established by medical societies had formal representation by at least one member from another profession. In King County, Washington, the agreement between the medical society and bar association establishing the plan provides that a single attorney representing the bar association meets with the panel of physicians, but does not vote. Some limited data were supplied by interview and indirectly to this study about the operation of the King County, Washington, panel, but its records were not made available for verification or case-by-case analysis.

The Hawaii Medical Association also falls in this category and is composed of nine physicians, one attorney, and a clergyman. The attorney is an advisor and does not vote, although the clergyman does. This plan, which operates under the Peer Review Committee, has several unique factors (in addition to being the only nonstatutory plan with a nonmedical-nonlegal member) which are discussed in subsequent sections of this report. This group granted permission to study its records too late in the project to include this interesting plan in the quantitative analysis of the report.

Medical-Legal Screening Panels

By far the most frequently encountered method of screening medical malpractice claims was the medical-legal or physician-lawyer screening panel.[7] These plans are popularly called "medico-legal" screening panels. Included in the study were six statewide and sixteen regional plans. Statewide plans are generally established in areas of low population density or in small states. Regional plans, by far the more popular, are operated on a countywide or regional basis. Detailed case records, offered by many plans, were obtained for quantitative analysis in the case-by-case comparisons from representative plans—one statewide plan in New Mexico and one regional plan in Pima County, Arizona.

Court-Sponsored Screening Panels

Two jurisdictions, New Jersey and New York, have established screening panels which are administered under their court systems. In New Jersey, the plan is operated on a statewide basis. In New York, a highly-publicized experimental plan is operated in the single trial court of general jurisdiction within the Borough of Manhattan. These plans can most accurately be characterized as mechanisms established to reduce large court backlogs in densely populated metropolitan areas.

In New Jersey, both parties exercise some degree of control over the operation of the plan. Upon adoption of its optional feature—for the plaintiff to drop his claim if the finding is against him—the medical society will provide an expert witness at trial should the panel find for the claimant, but the physician must consent to the procedure before a hearing can be held. The New York panel operates as a pretrial mediation panel, with a judge, physician, and lawyer trying to get the parties to settle.

Detailed cases were made available to this study by the New Jersey panel, and a summary of the results of the New York panel as reported by its organizers was also analyzed. Data adequate to fully assess the effectiveness of the New York panel will not be available for some time due to the docket delay.

Statutory Plan

Only New Hampshire has recognized the institution of the screening panel through its legislature. Under the statutory procedure in New Hampshire, claims against doctors, dentists, and lawyers are heard by a three-member panel composed of one judicial officer, one member of the public, and one member of the profession of the defendant

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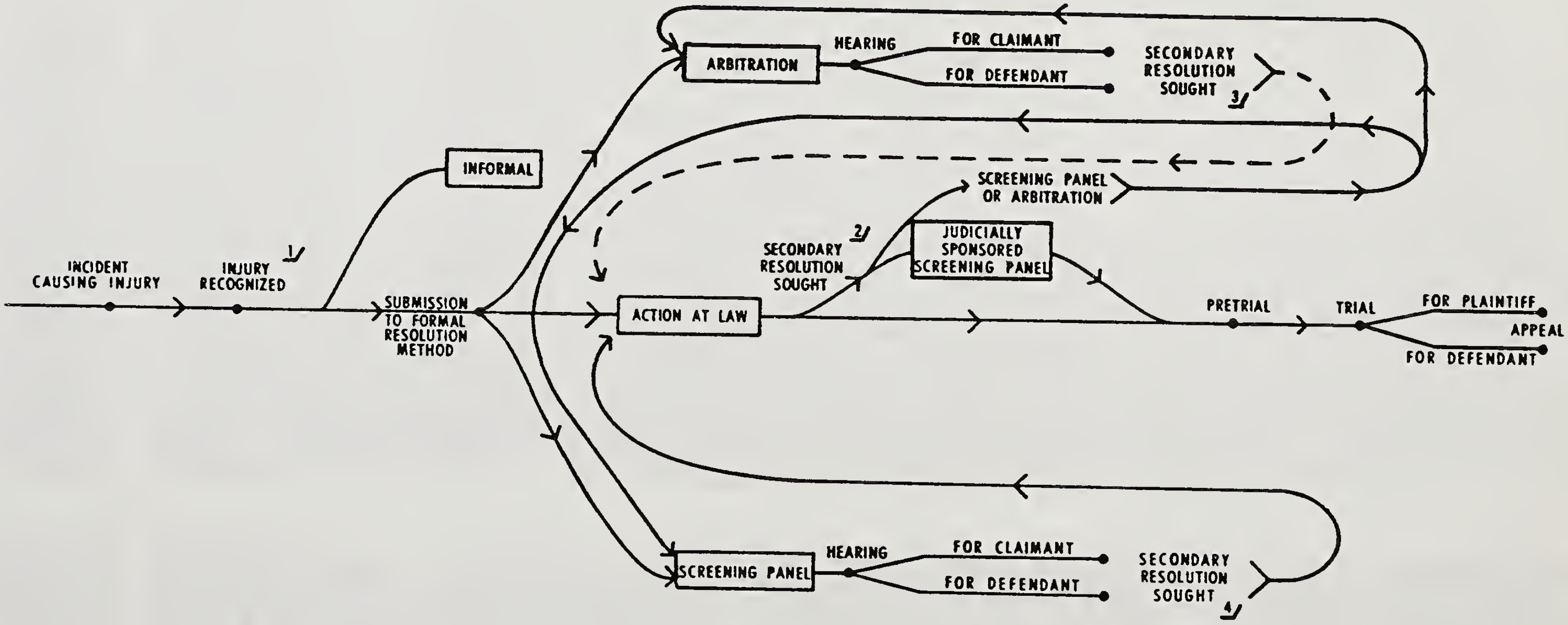
[5] The Insurance Closed Claims Study preliminarily estimates that 11.1% of all medical malpractice claims are reviewed by such a panel. See *supra*, pp. 1 ff.

[6] See Soden, "The New Hampshire Plan," 20 *Federation of Insurance Council Quarterly* 13 (Winter 1969-1970).

[7] The Insurance Closed Claims Study preliminary tabulations estimate that only 1.9% of all claims closed in 1970 were reviewed by medical-legal panels. See *supra*, pp. 1 ff.


INCIDENT CAUSING INJURY
INJURY RECOGNIZED 1/
INFORMAL
SUBMISSION TO FORMAL RESOLUTION METHOD
ARBITRATION
HEARING
FOR CLAIMANT
FOR DEFENDANT
SECONDARY RESOLUTION SOUGHT 3/
SCREENING PANEL OR ARBITRATION
SECONDARY RESOLUTION SOUGHT 2/
JUDICIALLY SPONSORED SCREENING PANEL
ACTION AT LAW
PRETRIAL
TRIAL
FOR PLAINTIFF
APPEAL
FOR DEFENDANT
SCREENING PANEL
HEARING
FOR CLAIMANT
FOR DEFENDANT
SECONDARY RESOLUTION SOUGHT 4/

NOTES:

1/ At any point during the claims resolution process, settlement may be reached by agreement of the parties to the dispute.

2/ Not infrequently, arbitration is forced on the plaintiff by the pleading and proof by the defendant of an arbitration agreement. Parties to a lawsuit may, of course, at any time agree to arbitrate their dispute. By contrast, screening panel proceedings are frequently conducted before and during actions at law, although in the many plans studied rules differ markedly as to the permissible use of the screening panel while an action at law is pending.

3/ The availability of secondary resolution methods after arbitration and award is very limited, depending on the validity of the arbitration agreement and the substantive and procedural law of the jurisdiction where it is employed.

4/ In contrast to arbitration, screening panels are only infrequently binding on the parties. While technically to complete the diagram, the parties might agree to arbitrate their dispute after a screening panel, the use of this alternative is too limited to be included in the figure.

FIGURE 1
ALTERNATIVE MEDICAL MALPRACTICE CLAIM RESOLUTION PATHS

against whom the claim is alleged. The New Hampshire plan differs materially and commendably from all other screening panels in that it not only determines the issue of liability but ascertains with particularity money damages as well. However, the finding of money damages is only advisory; the parties are free to accept or reject the finding of the panel and sue or settle. This unique facet of the New Hampshire plan, which provides a benchmark around which the parties may negotiate productively, is of noteworthy incidence and theoretically should lead to wider-spread settlement of medical malpractice claims in that jurisdiction.

The plans studied, listed in their above characterizations, are shown in Table 6.

Arbitration—Current Plans

There is widespread interest within the professional medical liability insurance community and the medical profession in employing the dispute resolution technique of arbitration in the medical malpractice claims arena. There are currently four arbitration plans operating solely as medical malpractice resolution mechanisms.[8]

Although the arbitration plans are more difficult to neatly categorize than the screening panels, the dimensions of their establishment which are of importance are the method by which arbitrators are selected, the type of medical care delivery services in conjunction with which the arbitration agreement is made, the contracting parties, the time of contracting, the scope of parties bound as defendants, and the reported effectiveness of the arbitration plans.

This section of the report briefly compares these dimensions in the four major arbitration plans studied. Since the following parts of this study are devoted to the subject of arbitration, and include an analysis of the four plans, this section treats the topic only generally.[9]

Ross-Loos Medical Group

The Ross-Loos Medical Group arbitration plan is the oldest of those studied. From its inception in 1932, it has enjoyed wide publicity for its arbitration provisions. In a widely publicized case said to stand for the proposition of acceptance by the Supreme Court of California of agreements to arbitrate medical malpractice, the arbitration contract litigated was made by Ross-Loos.[10] Subscribers to the services of the Ross-Loos Medical Group generally make their contracts for services (and their arbitration provisions) under a group subscriber agreement.

Southern California Hospital Association Experiment

This widely reported experiment in arbitration of medical malpractice claims instituted by a group of nine hospitals in Southern California is now regarded by its sponsors as evidence that arbitration has simply failed to demonstrate its oft stated virtue of speed in resolving medical malpractice disputes[11] After four and one-half years of operation, not a single malpractice claim has reached the actual arbitration stage.

Southern California Kaiser Foundation

This prepaid group comprehensive health care delivery system in Southern California uses party-appointed arbitrators rather than the offices of the American Arbitration Association. In general, subscribers to the Kaiser plan are by group contract. The scope of parties covered by the arbitral agreement within the Southern California Kaiser Foundation insurance contract is broader than any of the others. Here, too, no cases are reported to have reached actual resolution by the arbitral process.

Casualty Indemnity Exchange

This arbitration plan was instituted by the CIE insurance company (of Denver, Colorado) initially through the insurance contract with its insured physicians. Under the plan, the physician is afforded a reduced liability insurance premium from CIE, which is continued if a specified percentage of the physicians' patients thereafter enter into contracts with the physician to arbitrate future medical malpractice disputes. If not enough patients sign up, the physician's premium is adjusted upward retroactively. It is the only plan in which the bargain for medical care and treatment and arbitration is made directly between patient and physician. No arbitrated cases are reported.

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[8] The Suffolk County (New York) Screening Panel is included under the section immediately preceding. It is basically a medical-legal screening panel, but in cooperation with the local insurance carrier has been given limited arbitration jurisdiction. Supporters of the plan are enthusiastic for its future and seek to enlarge its claims disposition dollar limit. Many jurisdictions have statutory provisions for the arbitration of small claims or specific kinds of claims, but their aim is general; this report is focused on medical malpractice dispute resolution methods. An unpublished compilation by the American Arbitration Association, "Compulsory Arbitration Statutes and Rules" (September 21, 1972), lists seven jurisdictions with such compulsory plans.

[9] Preliminary data tabulations from the Insurance Closed Claims Study conclude that arbitration is the least frequently used alternative to litigation—only 0.71% of all 1970 closed claims.

[10] *Doyle v. Giuliucci,* 60 Cal. 2d 606, 43 Cal. Rptr. 697, 401 P. 2d 1 (1965).

[11] Compare, Ludlam and Hassard, "Arbitration", 44 J.A.H.A. 58 (1970) noting a particular goal of the project "...to speed the handling of claims so they can be disposed of in months rather than in years...", with letter from Howard Hassard to Eli P. Bernzweig, July 24, 1972, noting "...We are in the first month of the fourth year, and we still have not had an arbitration... I am beginning to suspect that whatever advantages arbitration may have, speeding up the decision process is not one of them....".

TABLE 6
KNOWN MEDICAL MALPRACTICE CLAIM SCREENING PANELS

Physician (6)	Physician and Advisory (2)	Medical-Legal		Court-Sponsored (2)	Statutory Plan[5] (1)
		Statewide (6)	Regional (17)		
Maine Medical Advisory Committee Med-Chi Faculty of Maryland New Hampshire Medical Society Idaho Medical Ass'n. Mediation Committee Portland, Oregon Rhode Island Medical Society	King County, Washington Honolulu County, Hawaii Medical Society	Alaska Colorado Delaware Montana New Mexico[1] Virginia	Arizona, Maricopa County Arizona, Pima County Florida, Hillsborough County Iowa, Scott County Idaho, South Central Region[2] Maine, Androscoggin County Maine, Cumberland County Nevada, Washoe County New York, Nassau County[2] New York, Suffolk County[3] Ohio, Columbus and Franklin Counties Ohio, Montgomery County Pennsylvania, Berks County Pennsylvania, Philadelphia Co. Washington, Spokane County Washington, Pierce County Wisconsin, Milwaukee County[2]	New Jersey New York[4]	New Hampshire Professional Malpractice Claims Statute

[1] New Mexico has two plans, one supported by the medical society and one sponsored by the Osteopathic Medical Association.

[2] Reported as defunct or never used.

[3] Primarily a screening panel, but with limited arbitration jurisdiction.

[4] Experimental.

[5] Several jurisdictions have statutory provisions for arbitration of small claims (e.g., Pennsylvania) but their aim is general rather than limited to medical or professional malpractice.

The company indicates[12] that although the rate of "occurrences" among physicians who are receiving the benefit of reduced premiums under the arbitration plan and those who are not is the same, occurrences which become "claims" are 5% lower than for the population of physicians which it insures who have not opted for the arbitration plan. In addition, CIE reports that there is an 8% increase in claims closed without payment for physicians who are under the arbitration plan as contrasted with claims against physicians who are not. From this observed result, the company has noted an immediate 13% reduction in the effect of claims and feels that the benefits of arbitration are great.

Sponsorship at CIE of the arbitral provision is enthusiastic, but whether the conclusion that the mere existence of the arbitration agreement with the physician acts to reduce claims or ameliorate their effect is a non sequitur or a valuable new finding cannot be determined at this juncture. The statistics graciously furnished by the company, however, were preliminary and identified as far from conclusive. When significant numbers (rather than percentages) of these observed events become available, their tests of statistical significance may shed light on the answer.

These attributes of the existing arbitration plans are contained in Table 7. For this study, detailed case-by-case data were obtained for only one arbitration plan indirectly from a companion study of the Ross-Loos Medical Group and, for that plan, consisted almost solely of settlements rather than arbitrated cases. This case information, along with that of the representative classes of screening panels, is analyzed and compared in a subsequent section of this report.

Problems of law associated with arbitration of medical malpractice in general and each of these arbitration plans in particular, and more precise descriptions of each of them, are extensively analyzed in "Alternatives to Litigation; III."

Section II
Quantitative Analysis - Data and Methodology

A. DATA COLLECTION AND ORGANIZATION

The focus of inquiry of this study was quantitative. This approach was selected because, although a great deal of subjective and well-reasoned information has been reported about the way in which various alternatives to litigation ought to work or are thought to perform, no comprehensive quantitative measure of their effectiveness has ever been made. The data for the study have been collected the hard way—by going to each site, getting access to the records, and recording the facts. The cases so gathered represent one of the prime data sources at the present time on medical malpractice.

Data were recorded from each case to show the essential dimensions of interest which could be either coded or quantified. Table 8 presents the sources of data used in this study. Over 2,400 cases have been analyzed in detail, coded in computer-operable format, and used in the statistical analysis to compare the performance of the various types of plans. Listed in the table are: the plan from which data were extracted, the type of plan in terms of its characterization noted in the previous discussion, the number of cases from which data were recorded, and a summary description of any significant remarks or limitations about the particular body of data analyzed.

Available data varied widely in the plans, depending on the practice of the administrators. Cost data proved difficult to obtain and in almost all instances it was necessary to contact collateral sources for this information. In several jurisdictions, complete access to data files was given to the study team. Access in other jurisdictions was somewhat limited and was supplied in the form of records with material which the plan administrators considered sensitive (primarily names) deleted. Actions at law were studied by review of public records in the courts. In those jurisdictions which provided the names of the parties appearing before the screening panel, court records were also examined to determine if an action at law had been filed involving the parties appearing before the screening panel. Through these many sources, complete traceability was found for many claims—from incident through screening panel through action at law and, in several cases, through appellate courts.

Two jurisdictions had accumulated records of medical malpractice actions at law over a period of several years for the purpose of evaluating the worth of establishing an alternative to litigation procedure in their jurisdictions or for assessing the medical malpractice problem objectively. These lists of cases, prior studies, and the raw data from a number of attitudinal surveys, and other studies (largely designed for other purposes) were generously made available in support of data collection and analysis performed for this report.

Appendix A shows the complete realm of data items obtained for each case and the computer format in which they were tabulated for analysis. In summary, the data classes extracted fell into the following categories:

- The plan or forum hearing the claim
- Type of action in resolution
- Number of defendants
- Characteristic of defendants and their subcategories
    - Physician
    - Surgeon
    - Hospital
    - Medical services
    - Medical supplies
    - Manufacturer
    - Employee
    - Other

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[12] Letter from Edward T. Rickard, Jr. to Bird Engineering-Research Associates, Inc., August 25, 1972.

TABLE 7

COMPARISON OF EXISTING MEDICAL MALPRACTICE ARBITRATION PLANS

Name of Plan and Selection of Arbitrators	Type of Health Services	Contracting Parties	Time of Contracting	Scope of Parties Bound as Defendants	Reported Number of Arbitrated Cases
■ Ross-Loos Medical Group (Party-Appointed Arbitrators)	Prepaid Group	Patient-Group	Pretreatment	1. Group	3
■ Southern California Hospital Association (AAA - Commercial Rules + Supplement)	General Hospital	Patient-Hospital	At Admission (With 30-day escape after discharge)	1. Hospital 2. Admitting Physician - unless has not agreed in writing to be bound 3. Other Parties, if so elect	0
■ Southern California Kaiser Foundation (Party-Appointed Arbitrators)	Prepaid Group	Patient-Group	Pretreatment	1. Health Plan 2. Hospitals 3. Medical Group 4. Southern Permanente Services, Inc. 5. Any Employee or Partner of Above 6. Other Parties, if so elect	0
■ Casualty Indemnity Exchange (Party-Appointed Arbitrators)	General Physician	Patient-Physician	At Treatment (With 30-day escape after making or notice -- ambiguously drafted)	1. Insured Physicians in California, Colorado, Kansas, Indiana, Minnesota, and Wisconsin	0

TABLE 8
DATA BANK STATUS

Data Source	Type of Plan	Cases Analyzed		Remarks
		No.	Type	
Maryland	Statewide Physician Screening Panel	381	Physician Screening Panel, Actions at Law, and Settlements.	Some limitations on thoroughness of defendant recording
New Mexico	Statewide Medical-Legal Screening Panel	93	Screening Panel	Actions at law not collected
Arizona, Pima County (Tucson)	Regional Medical-Legal Screening Panel	40 38	Screening Panel Actions at Law and Settlements	Complete and thorough
Arizona, Maricopa County (Phoenix)	Plan similar to Pima but recently established—court data only considered in this study	78	Actions at Law and Settlements	Complete and thorough
New Jersey	Statewide Court-Sponsored Screening Panel	179	Court-Sponsored Screening Panel	Complete and thorough
California, Ross-Loos Medical Group	Group Practice Arbitration Plan	33	Arbitration and Settlements	Mainly Settlements
United States District Court for the District of Columbia	Federal Court of General Jurisdiction	10	Actions at Law	Test data only
Jury Verdict Research, Incorporated	Commercial Case Evaluation Service for Attorneys; Large Nationwide Data Bank	1578	Medical Malpractice Cases	Wide geographic but non-random selection

- The medical "syndrome" or the alleged breach of medical duty from which the claim arose was recorded in up to 100 "open ended" descriptions for later combination and analysis. The major syndrome topics and number of open ended subcategories are:
  - Failure to diagnose (36)
  - Improper treatment (16)
  - Anesthesia incidents (4)
  - Transfusion incidents (2)
  - Injection site injury (8)
  - Patient abandonment (1)
  - Gross patient misunderstanding (2)
  - Noteworthy legal theory (6)
- The sex of the claimant
- Screening panel or action at law disposition

In addition to the data extracted from records of the screening panels and their corresponding judicial forums, a large volume of data from reports of litigated cases was obtained from Jury Verdict Research, Inc., which provides a commercial injury evaluation service to lawyers.[13] This data was gathered and coded for use as a basis of comparison with cases settled by alternatives to litigation. The data from Jury Verdict Research was characterized for later use and study in accordance with the existing breakdown used by that organization. These classifications generally begin with a major heading involving the part of the body affected, with subcategories of specific medical injury. Locality of the occurrence of injury was coded by the U.S. Postal Service zip code.

B. ESTABLISHMENT OF SEVERITY INDEX

Each injury arising out of a medical incident as described in the file reviewed was scored in terms of a "severity index", by which the probable extent of relative legal and monetary damages in the claim was rated on a scale from one to eight. Death cases (step 9 in the index) were placed in a special category due to the need for differentiating between many differing rules of law regarding wrongful-death cases, principally in the statutes of limitations compared to other personal injuries and the statutory maximum amounts placed on damages by many jurisdictions. The coding rules by which the severity index was employed is shown in Table 9.

The purpose of the severity index is to provide a single relative measure of the seriousness of the case relative to its legal elements of damage, and to facilitate the comparison of groups of cases. This purpose is difficult to achieve because each injury is unique, but minor ones can be distinguished from major and the degree of recovery can be described (within limits), the time interval of recovery factored in, and an approximation of pain and suffering made. Sometimes, elements of special damages such as the amount of medical expenses can also be taken from the data. This scale brings together these different aspects of severity into a single number.

An index might be created individually for each of these factors, and there might be other aspects of injury such as the amounts of medical expenses, the amount of lost earnings, the incapacity for learned skills, and so forth. Including all these might easily make a scoring system that is too complex to use for the quality of raw data available, and would tend to defeat its purpose; that is, simply describing whether the cases that go through one method of resolution (the screening panels and arbitration) are of a different order of severity than those that go through others (legal action only), and whether cases in some states or sections of the country are more or less severe than those in other areas, and the relationship of severity to settlements and awards.

Many such attempts have been made in the past to develop a scale for the severity of injury, but none of those examined appeared suitable for the purpose intended here. The Med-Chi study of medical malpractice in Maryland[14] used a 7-point scale, but there appeared in practice to be little distinction among the first three steps and among the last three (excluding step 7—death). In a study of hospital-induced medical injury, Dr. John S. Boyden adopted the Social Security 5-point scale, but in actual practice used only three points—major, minor, and death.[15] Dr. Robert Verhalin adopted an 8-point severity scale for the measurement of emergency room injuries caused or resulting from the use of consumer products in connection with the work of the National Safety Conference.[16] A paper by Dr. John D. States, "The Abbreviated and the Comprehensive Research Injury Scales", analyzed some twelve research articles dealing with the subject. All of the scales investigated proved to be unsatisfactory, but all conceded the important purpose that such a scale might have.

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[13] Jury Verdict Research, Inc., of Cleveland, Ohio, has devoted itself to collecting, verifying, classifying, analyzing, publishing, and preserving records of personal injury verdicts throughout the nation. The firm was founded by a lawyer in the late 1950s to assist plaintiff and defense lawyers in evaluating the probable worth of claims, to provide a medium of informed settlement negotiation, avoiding lengthy and costly trials. Many valuable studies are suggested by this bank of data which includes, for example, categorization of plaintiffs and defendants by age, sex, minority group, injury, geographic area, and the like. See, *Time,* "The Law, Torts, Outguessing the Jury" (May 15, 1964). While this study has used raw data from JVR files of medical malpractice cases and consulted extensively with its analysts, the analysis and conclusions herein are solely those of Bird Associates.

[14] Friends Medical Science Research Center, Inc., "A Survey of Professional Liability Incidents in Maryland" infra, pp. 623 ff.

[15] John S. Boyden, "A Survey of Medical Injuries Described in Hospital Patient Records," *supra,* pp. 41 ff.

[16] National Commission on Product Safety, *Supplemental Studies, Vol. 1, Product & Injury Identification,* Appendix A, "Generation of a Frequency-Severity Index", (June 1970).

TABLE 9
SEVERITY INDEX

Degree	Index Number	Description	Examples
	0	Unknown	
Minimum	1	Psychological Injury Only	Fright, worry, anguish
↓	2	Complete Recovery	Minor scar
	3	Prolonged Recovery	
	4	Pain and Suffering - Prolonged Recovery	
	5	Pain and Suffering - Permanent Injury - Minor	Limp
	6	Pain and Suffering - Permanent Injury - Significant	Amputation of Limb
	7	Great Pain/Prolonged Suffering - Permanent Injury - Major	Blindness, loss of both legs
	8	Grave Permanent Injury - Lifelong Care	Comatose
Maximum	9	Death	

The severity scale developed was found to be useful for the purpose intended. It is a continuous, subjective 8-point quantification of many dimensions embraced within the concept of legal damages: the severity of injury, the degree of permanence, delay involved in recovery, and the pain and suffering resulting from the injury. Although the many individual cases analyzed do differ in the many dimensions which make up legal damages, the net result of the application of the scale is a reasonably progressive one.[17]

Although exact tests of concordance were not conducted to test the degree to which different scorers might differ in their interpretation of specific cases, trials have shown that the difference between scores has seldom been more than one step and almost never as much as two steps. Additionally, only a few individuals, who work closely in daily communication, applied this scale, ensuring consistency in its interpretation for the purpose used.

When groups of cases from a variety of sources have been scored, the combined severity score distributions have shown a similar frequency pattern with a marked central tendency, with the scores of 4 and 5 being markedly more frequent than those smaller and larger values, except of course for step 9 (death), which appears as a modality of its own. This central tendency suggests a normal frequency in which the average value (of severity) is meaningful and in which shifts of the average value will reveal changes in the severity composition of the injuries being described.

Figure 2 shows (in the inset) the distribution of the severity index applied to 1,578 medical malpractice jury verdicts from the data files of Jury Verdict Research, Inc. The figure illustrates implicity the suggested normality which the index produces by its use upon a large body of "real world" data.

One would anticipate from the theory of large numbers that information selected from a large population of data would follow a normal distribution. The plot of severity versus cumulative probability in Figure 2 illustrates a test for normalcy. Unknown and death categories were excluded from the analysis due to their nonordinate properties. The ability to formulate a straight line from the data is a strong indication of its normalcy. The implication of a normal distribution gives strength to the mean (or average value) of the distribution as a meaningful indicator of the population, as previously discussed.

The severity index, viewed in terms of the application to the cases in hand, thus does work well as the practical measure intended. It will serve the purpose of showing whether the population of injuries resolved through screening panels and arbitration are more trivial or less severe than those going directly to legal adjudication.

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[17] This is in contrast to the severity scale employed in the related Insurance Closed Claims Study. That scale, which must be interpreted and applied by many individuals, is designed to distinguish between delayed recovery and (apparently) immediate recovery versus ranges of severity within the two recovery time dimensions. In that sense, it is not an ordinate scale and for a comparable body of litigated cases to those analyzed in this study might produce a bimodal distribution.

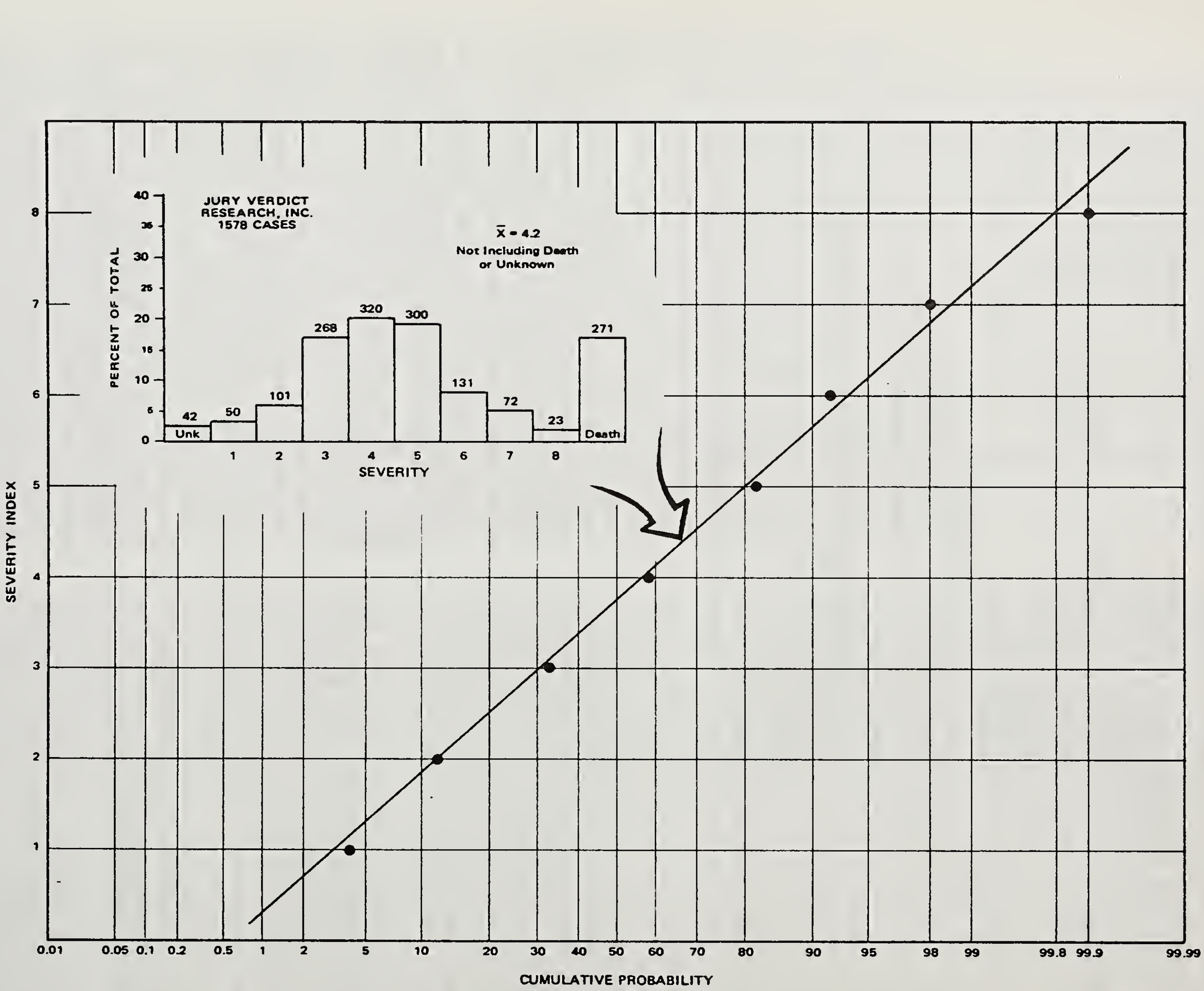


FIGURE 2
TEST FOR NORMALCY OF SEVERITY INDEX

C. A COMPARATIVE MEASURE OF JUSTICE—THE DECISION RATIO

Throughout this report it is emphasized that conclusions are drawn only on a comparative basis between actions at law and the alternatives to litigation. There is no method by which an abstract quality such as justice can be measured, but for dimensions of performance which can be quantified, results can be compared and inferences drawn that the various forums are behaving in the same way or differently. The most difficult element to quantify is whether the plans and their decision-making bodies render just decisions. The problem was resolved in this study by adopting a simple decision ratio:

$$\text{Decision Ratio} = \frac{\text{Plaintiff Decisions}}{\text{Plaintiff Decisions} + \text{Defendant Decisions}}$$

The ratio proved effective in comparing the performance of the various plans because it can be used alone or in combination with other quantified dimensions such as case severity. Illustrations and results of this analysis will be shown in subsequent sections.

D. SPEED AND ADMINISTRATIVE EFFICIENCY

Many time intervals were obtained from the records of closed cases. This allowed the comparison of the dispatch with which the various plans for resolving disputes performed their stated functions. This analysis was not only conducted on a relative basis, but was one of the few dimensions which could be quantified on an absolute basis. The intervals were obtained by computer processing of noted events. Events coded included the date of the incident, the date it was recognized, the date of submission of the claim to the particular method of resolution, the date of hearing by the particular forum, and the date of decision or final settlement. For a number of cases, incomplete information was obtained, but enough information was found from a significantly sizeable number of cases in each jurisdiction to make comparisons among them meaningful.

E. SETTLEMENT PRACTICES IN ACTIONS AT LAW

One of the most frequently stated objectives of screening panels is their aim to deter lawsuits, encourage settlements, and reward meritorious claims. The data base contained in the Jury Verdict Research, Inc., files recorded information on:

- Plaintiff's final demand,
- Defendant's final settlement offer,
- Jury verdict (if a verdict was awarded to the plaintiff).

This information, along with the other case characteristics noted in the data-recorded section of the report, was obtained for verdicts for plaintiffs against 761 defendants and verdicts for 1465 defendants.

This allowed the analysis from an economic and behavioral standpoint of plaintiff and defense attorneys as they immediately entered an action at law, and when coupled with the decision ratio and severity index of the cases analyzed, afforded an interesting perspective of perhaps why cases are tried rather than settled. These, along with other results of the analysis, will be discussed in the following sections of the report.

In addition to the demand, offer, and settlement practices of plaintiff and defense attorneys from an economic standpoint, detailed comparisons of cases which had been the subject of inquiry before both screening panels and actions at law in key jurisdictions were analyzed to determine whether cases settled and not settled as a result of screening panel findings had any unique characteristics.

Since only three medical malpractice cases have been actually arbitrated (as disclosed by a companion study to this report), severity and settlement amounts for settled and arbitrated cases were analyzed along with the apparent value of legal representation to the claimant.

F. COMPARATIVE COST ANALYSIS

As part of the evaluation of alternatives to the existing judicial system for resolving medical malpractice claims, a comparison was made to establish the relative differences between the dollar cost to complete proceedings by five methods: actions at law, three kinds of screening panels, and arbitration. The action at law was the comparison base. The three screening panels analyzed were physician screening panels, medical-legal screening panels, and court sponsored screening panels. Although five types of screening panels were identified earlier, the three chosen for cost comparison and analysis are representative of the entire group. The physician-and-advisory panel is similar to the physician screening panel, and the New Hampshire statutory panel is somewhat similar to the court sponsored plans.

This comparative cost analysis was simplified by assuming the issues in controversy and their legal complexity have a generally direct relationship to injury severity.

The objective was to determine the estimated total cost of conducting procedures by each method of resolution; therefore, neither amounts of settlements or verdicts nor decision ratios were considered necessary in the analysis. A final simplification in the pricing analysis was that the dispute was settled by the forum hearing it. That is, appeals from actions at law, judicial contests of the validity of arbitration agreements or proceedings, and actions at law after a screening panel were not analyzed, since they represent case and situation-unique cost factors which cannot usefully be generalized.

Three representative control or "test" controversies were formulated and then priced, step-by-step, for the procedural stages of the five alternative dispute-resolution mechanisms considered. In the analysis, the number of defendants in every case was held to one, while other cost elements (such as the number of expert witnesses, the number of depositions taken, the time spent in discovery and in medical and legal research) were varied on the basis of differing case complexity. Trial and hearing times were also varied.

The results were analyzed in order to obtain an understanding of the relative cost of each major phase of each alternative mode—investigation, preparation, and hearing. Additionally, and of greater significance with respect to the study, the total cost (i.e., plaintiff cost, defendant cost, and other out-of-pocket costs) of each settlement mode over the range of severity levels was related to the cost of litigation for mid-range severity by a series of index numbers. With this device, it is possible to gauge the relative cost, with respect to actions at law, of resolving the same case via the different modes of resolution considered in the scope of the pricing analysis.

Section III
Analytical Results and Discussion

A. CHARACTERISTICS OF CASES CONSIDERED BY THE DISPUTE-RESOLUTION SYSTEMS

This section of the report presents the results of applying the analytical techniques to the data base, as described in the preceding section, to determine whether and to what extent the alternatives to litigation differ from each other and from actions at law. Discussed in subsequent sections is the way in which these alternatives to litigation and the litigation process seem to exhibit preferences for the types of defendants whose cases are accepted, deal with cases in terms of their severity, make decisions for the plaintiff and defendant, and combine a number of these factors in varying ways to answer the central question of how cases are handled and disposed of. The central inquiry of this analysis is whether each of these ways of resolving disputes is (on a comparative basis) rendering just decisions, and dealing with the same or different kinds of claims and parties.

Classes of Defendants

An initial step in the analysis was to determine the kinds of defendants whose cases are heard before the various alternatives to litigation, compared to those heard by actions at law. In Table 10 is displayed the relative importance of defendants in the particular dispute resolution forums.

Distributions of defendants for 1578 plaintiff and defense verdicts from the Jury Verdict Research, Inc., data files are shown in the left side of the table. These are listed in the table in the rank order and frequency of their occurrence for the six most important defendant classes. Although the JVR data is not randomly selected, it is a large representative population of medical malpractice litigated cases, and therefore, in this initial overview of the manner in which the various alternatives to litigation afford a forum based on class of defendant, provides an instructive basis for comparison.

Noted in the table is that slightly more than half of the cases involve a single defendant. Multiple defendant cases (all two-defendant cases) comprise an additional 32% of the JVR data bank. Also noted in the table are that hospitals are the primary individual party defendants and the primary two-party defendant case is the hospital and surgeon combination.

TABLE 10

RELATIVE IMPORTANCE OF DEFENDANT CLASSES—ACTIONS AT LAW AND ALTERNATIVES TO LITIGATION

ACTIONS AT LAW A/			ALTERNATIVES TO LITIGATION									
			Physician Screening Panel B/		Medical-Legal Screening Panels				Court-Sponsored Screening Panel E/		Arbitration F/	
					Statewide C/		Regional D/					
Rank Order	Percent	Defendant Class	Rank Order	Percent	Rank Order	Percent	Rank Order	Percent	Rank Order	Percent	Rank Order	Percent
①	19	Hospitals										
②	17	Physicians	②	35	①	62	①	78	①	53	②	39
③	15	Surgeons	①	65	②	20	③	4	③	13	①	61
Half	51%			100%		82%		82%		66%		100%
④	14	Hospital & Surgeon										
⑤	13	Hospital & Physician					②	13	⑤	2		
⑥	5	Physician & Physician			③	7	④	4	②	23		
	83%					89%		99%		91%		

A/ Jury Verdict Research, Inc., Data Files (1578)
B/ Medical-Chirurgical Faculty of Maryland (80)
C/ New Mexico (90)
D/ Pima County (Arizona) (23)
E/ New Jersey (179)
F/ Ross-Loos Medical Group (31)

By contrast to this representation of defendants in action at law, the screening panels indicate a differing degree of focus on parties defendant as derived from the cases analyzed in detail from each plan. The small number of cases in the data for a number of plans makes percentage comparisons somewhat hazardous, but the rank order frequency can provide some definite conclusions. Although hospitals were by a slight percentage the primary defendants in actions at law, no alternative plan whose cases were analyzed yielded data indicating that they have more than infrequently served hospitals in the resolution of claims. It is perhaps in this regard that a number of arbitration experiments being conducted by the Southern California Hospital Association members and the arbitration clause adopted by the Southern California Kaiser Foundation are endeavoring to fill a need.

There are several additional limitations in the data displayed in the table. Although the regional medical-legal screening panel indicates that two-defendant combinations (hospital and physician) are second in rank order of importance, it should be noted that this data was derived generally from the style of the cases heard, and frequently the panel does not determine the liability of non-natural or corporate persons other than where ownership is solely by members of the medical society.

What can be concluded from the table is that major types of alternatives to litigation seek to serve only physicians and surgeons. As will be later described, this jurisdictional limitation is an important deficiency of the alternative plans. There is an apparent trend away from this exclusive jurisdiction, however, in the rules of the newer screening panels. The court-sponsored screening panels and newer arbitration plans will also hear and decide claims alleging liability against hospitals, as well as those against physicians or surgeons alone.

Number of Defendants

Figure 3 shows the distribution of numbers of defendants in the aggregate of all cases analyzed for screening panels and actions at law. From the data sources noted, the screening panels show a singular preference toward cases involving a sole defendant. By contrast, actions at law show a great propensity to hear and decide claims involving more than one defendant. This is so because all jurisdictions have for many years employed rules of legal procedure by which a single controversy may be litigated against all parties who might ultimately be liable for injuries to the plaintiff.

Differences in Severity

One question answered by the study was whether alternatives to litigation see differing kinds of cases in terms of their severity. The development of the severity index, a nine-point ordinal, subjective quantification of the many dimensions of legal damages in a medical malpractice claim, was discussed and described in the preceding section of the

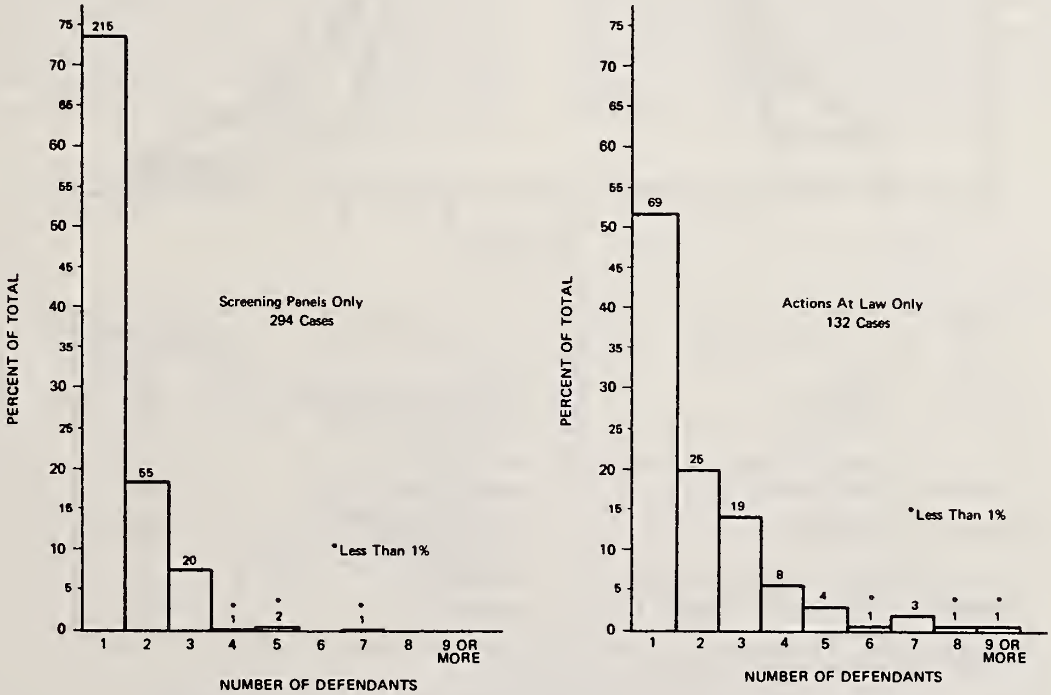
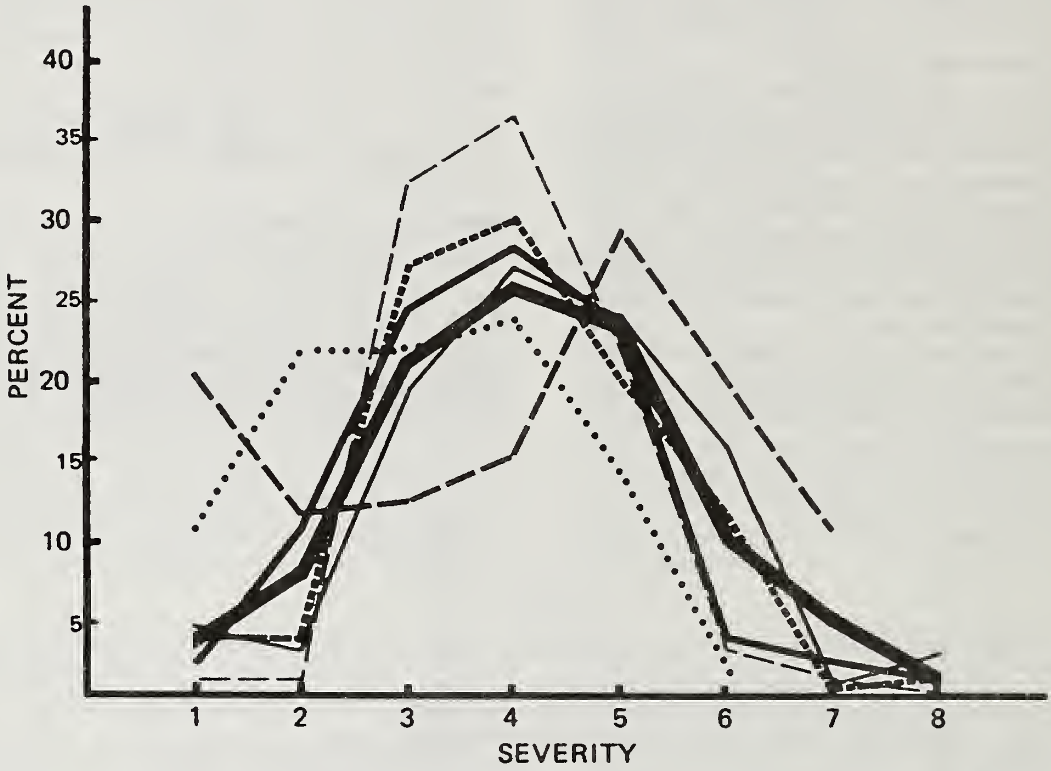


FIGURE 3
COMPARISON OF NUMBERS OF DEFENDANTS IN
SCREENING PANELS AND ACTIONS AT LAW

report. One example of its use is the plot shown in Figure 4 of the percent of cases versus their severity index heard by all of the dispute resolution systems. Differences in the mean severity and shape of the severity distribution for the cases considered in the study are shown in the figure. Omitted from the figure are unknowns and wrongful death actions (steps 0 and 9 of the severity index). Although these distributions differ, they do not do so markedly with the exception of the data shown for all cases in the Maryland data and the Ross-Loos Medical Group, an arbitration plan.

Arbitration

This differing behavior of the Ross-Loos Medical Group in terms of its distribution of percentage severity may be explained by noting that of the 33 cases for which data were available, 30 of them were settlements. Of the total number of cases reported in the Ross-Loos study, only three had reached the formal hearing stage. By contrast, cases in all other plans whose severity distributions are shown in the figure had reached the formal hearing stage. This suggests that the comparison is indicative of



Key	Data Source	Type of Forum	No. of Cases*
— - — -	Maryland	Physician Screening Panel	298
———	Pima County, Arizona	Regional Medical-Legal Screening Panel	62
— — —	Maricopa County, Arizona	Action at Law	58
--------	New Mexico	Statewide Medical-Legal Screening Panel	88
━━━	New Jersey	Court Sponsored Screening Panel	146
••••••••	Ross-Loos Medical Group	Arbitration	29
▬▬▬	Jury Verdict Research, Inc.	Action at Law	1265

*Death and Unknowns Not Included

FIGURE 4
SEVERITY DISTRIBUTION VERSUS FORUM—ALL PLANS

one plan representing a large class of settled cases (without formal hearing) as contrasted to a number of other plans which have reached the formal hearing stage.

The Ross-Loos case severity data can be broken down to display interesting conclusions, however, when cases settled by attorneys for the claimant are separated from those settled by the claimant himself. These two dimensions of claims settlement practices are broken apart and shown in Figure 5, which notes on the left side the distribution of the percent of cases versus their severity index for settlements reached with and without attorneys. Noted in the figure is the tendency for self-representation in low severity claims, with attorneys representing a greater percentage of claimants as the claims become more severe.

The effect of attorney advocacy on the amount of dollars awarded to claimants is also shown in the figure. Plotted on the right side of the figure are the average awards paid by the Ross-Loos Medical Group to claimants for medical malpractice injuries versus claim severity. No claim in the data reported exceeded $5,000, on the average, at any level of severity when the claimant was without an attorney. By contrast, even for claims of the same severity, claimants at Ross-Loos represented by an attorney achieved about twice the average settlement as did their counterparts without representation. It is concluded from this analysis that, on the average, even when claims are settled without formal legal action, the claimant, when represented by an attorney, receives a greater amount for like injuries, even after paying his lawyer the customary one-third contingent fee, than when he represents himself.

This array of case settlement practice at Ross-Loos poses a serious question of whether it is an "arbitration plan" at all. Although advocates of binding arbitration of medical malpractice claims continue to advance the seemingly reasonable proposition that arbitration is ideal for the small claim whose economic worth would not justify an action at law, the only hard data reported about arbitration, that from Ross-Loos, shows that not a single small claim has been arbitrated. Injured patients with small claims either opt for (or perhaps are encouraged to accept) small settlements in lieu of the arbitration procedure and frequently do so without the advice of an attorney, all to their apparent financial detriment. Rather than a true alternative to litigation in the form of a complete substitute for an action at law, the Ross-Loos data suggests that the plan may be only a combination of settlement practices instead of the widely-pursued just, speedy, and inexpensive method of dispute resolution.

The comprehensive analysis of contractual problems in arbitration of medical malpractice[18] concludes that the ultimate success in the courts of arbitration agreements perhaps depends more than any other factor on the skill and fairness in marketing it by the medical and insurance communities to the American consumer. The data analyzed from the Ross-Loos plan suggests that if arbitral agreements are to pass muster in this context, greater emphasis must be placed on actual use and validation of the arbitral process.

Screening Panels

The kind of cases in terms of their severity heard before all screening panels is shown in Figure 6, which indicates that most of the screening panels hear about the same kinds of cases. There is, however, a markedly different pattern in the severity of the cases heard by the Maryland physician screening panel and a slight difference in the Pima County, Arizona medical-legal screening panel. Included in the figure for comparison is the Jury Verdict Research, Inc., distribution of action at law severity index.

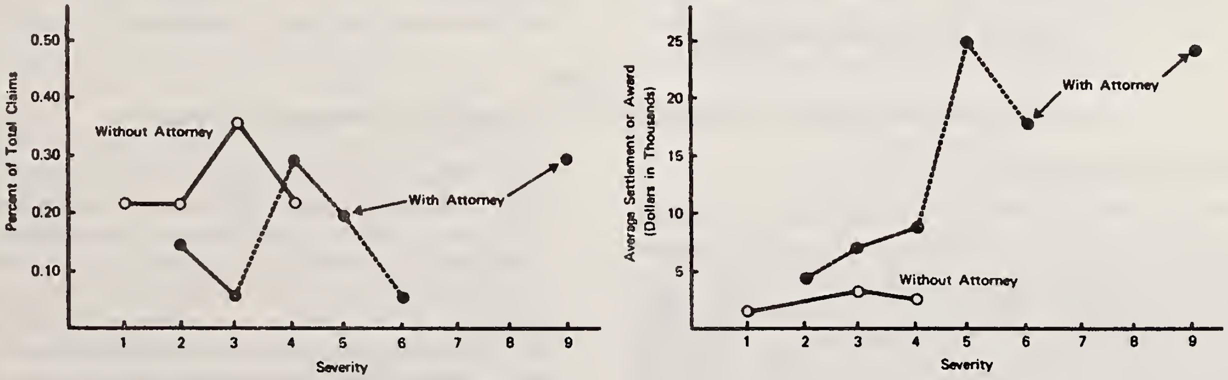


FIGURE 5
ROSS-LOOS MEDICAL GROUP (ARBITRATION)—SEVERITY AND
AWARDS FOR CASES SETTLED WITH AND WITHOUT ATTORNEYS

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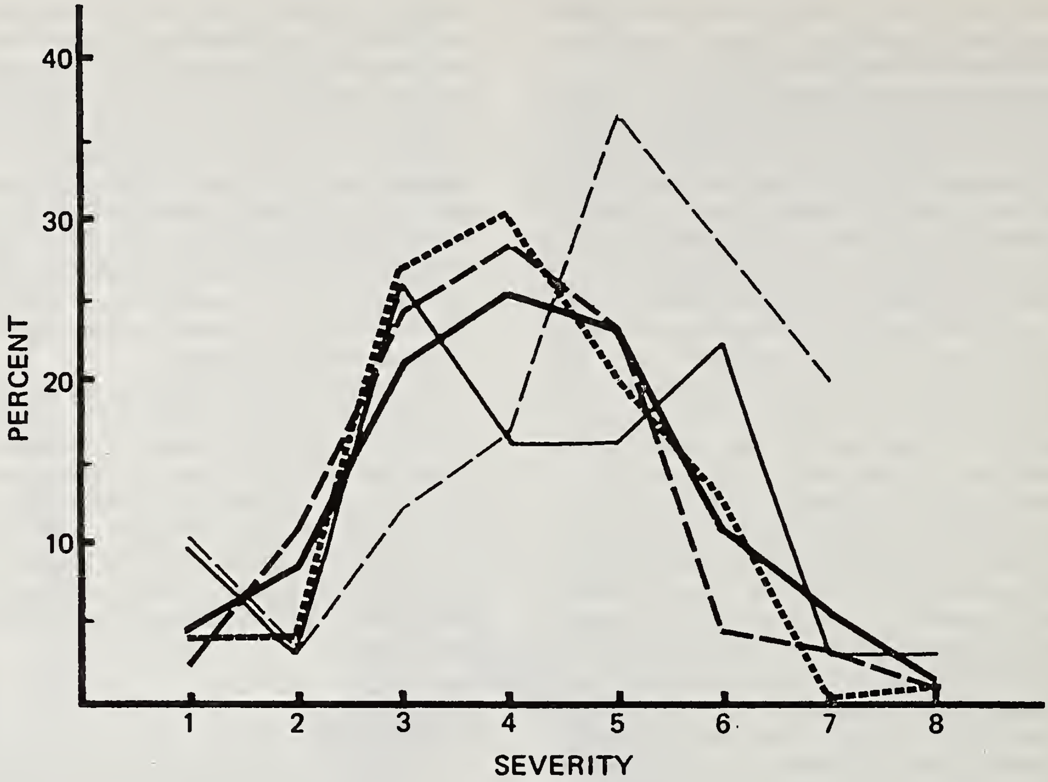
[18] "Alternatives to Litigation: III", *infra*, pp. 321 ff.



Key	Data Source	Type of Forum	No. of Cases*
– – – –	Maryland	Physician Screening Panel	60
———	Pima County, Arizona	Regional Medical-Legal Screening Panel	31
▪▪▪▪▪	New Mexico	Statewide Medical-Legal Screening Panel	88
━ ━ ━	New Jersey	Court Sponsored Screening Panel	146
━━━	Jury Verdict Research, Inc.	Action at Law	1265

*Death and Unknowns Not Included

FIGURE 6
PERCENTAGE OF CASES VERSUS SEVERITY IN SCREENING PANEL HEARINGS

Physician Screening Panel

This difference in the Maryland panel is an important finding for, as is shown in Figure 7, this panel (composed only of physicians) tends to review a greater proportion of suits having a higher index of severity than do other dispute resolution forums. The underlying reason for this perhaps lies in the stated purpose of that type of plan. Physician screening panels are established in conjuntion with the medical society and the professional liability insurance carrier. These physician panels have as their main purpose reaching a decision whether to settle or contest a claim, rather than disposing of it in a fair, impartial, and just manner as an action at law would attempt to do.

There are indications that even though the physician screening panel is formed to benefit physicians, they, as well as the consumer, may not totally benefit from them. Several persons in the insurance industry working closely with these local medical societies informed members of the study team that the physician screening panel was a helpful device to the insurance carrier in continuing to market a group policy, even in the face of rising premiums, when it could be pointed out to the insured physicians that they collectively participated in the decision-making as to which claims should be contested or settled and therefore bore at least partial responsibility for the cost of their insurance.

Medical-Legal Screening Panel

The use of medical-legal screening panels is enforced only through agreements between the local medical society and bar association. Enforcement is, therefore, brought about solely by peer pressure. The degree to which this

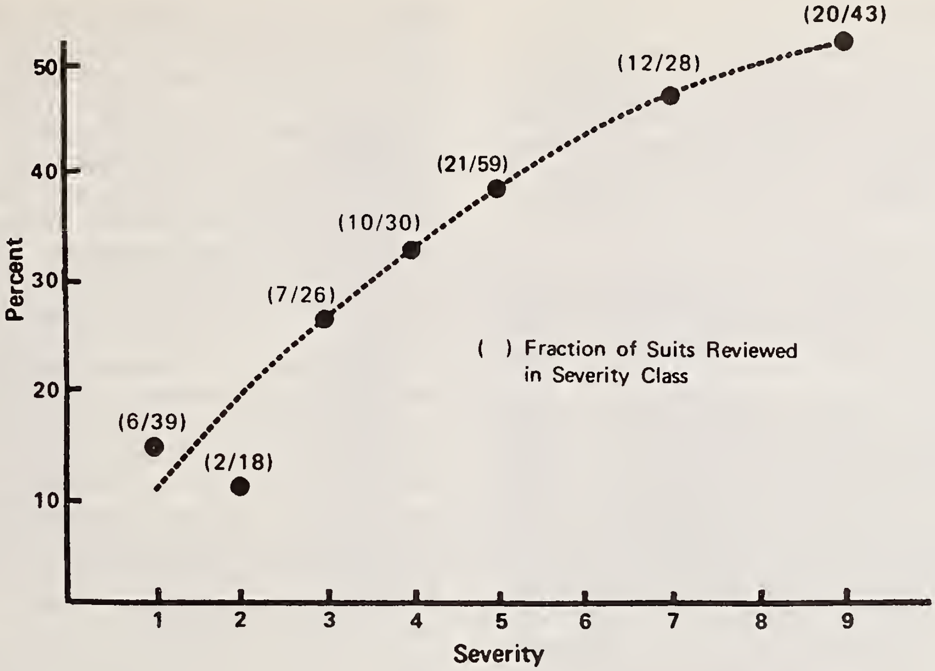


FIGURE 7
MED-CHI CASES REVIEWED VERSUS SEVERITY

interprofessinal agreement has been adhered to in one plan studied in depth will be discussed in a subsequent section of this report. Of immediate interest, however, are the various alternative ways, within a particular jurisdiction in which there is a screening panel, that the panel might be used in conjunction with the action at law. The decisions facing a claimant's attorney would be to ignore the interprofessional agreement and proceed directly to an action at law. Conversely, the action brought to the screening panel may be abandoned as a viable claim upon a finding of no negligence by the physician. Irrespective of the finding of the screening panel, an action at law may be brought either before, during, or after the proceedings have be instituted or decided at the screening panel.

The information displayed in Figure 8 shows the distribution by percentage of cases versus their severity within Pima County, Arizona over this realm of alternative ways in which the screening panel is used. Due to the small number of data points for cases which were resolved only at the screening panel level, this curve cannot be interpreted with certainty. It suggests, however, that a slightly higher percentage of lower severity cases are disposed of by the screening panel than by the action at law, or by the screening panel in conjunction with the action at law. This is an important finding, for the Pima County screening panel severity distribution is in sharp contrast to that discussed earlier for the Maryland physician screening panel. That is, while the Pima County medical-legal screening panel exhibits a multi-modal distribution of severity for cases disposed of by it, it does not indicate a preferred tendency toward the more severe cases as was the situation with the physician screening panel.

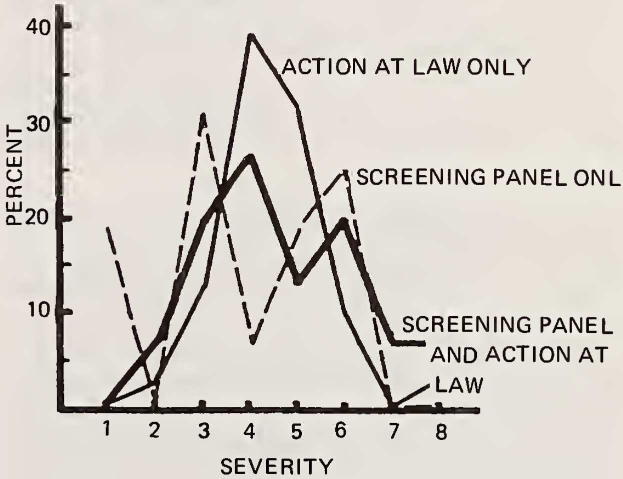


FIGURE 8
PIMA COUNTY, ARIZONA–
FORUM VERSUS SEVERITY

It is to be recalled that the purposes behind these two types of alternatives to litigation differ sharply and perhaps explain the reason for this behavior. The sole purpose of the Maryland panel is to assist in evaluating claims against physicians. The underlying purpose of the Pima County medical-legal screening panel is to bring all claims before this body as a result of an interprofessional agreement between the physicians and the bar. Irrespective of what else might be inferred from the severity distribution shown in the figure, it is clear that the Pima County medical-legal panel does not exhibit a tendency to hear a greater or lesser proportion of trivial or serious claims.

Court-Sponsored Screening Panel

As indicated in Figure 6, which displayed the percentage of cases before the screening panels, those cases heard by the New Jersey Court-Sponsored Screening Panel are almost identical to the distribution shown in the figure for actions at law. This is perhaps so because the overwhelming majority of cases which that panel hears are from lawsuits already filed.

Information to assess the severity of cases was not obtained for the New York panel, but since its cases were also taken from existing lawsuits in the pending docket, there should be little difference in screening panel cases and actions at law.

This, then, is a comparison of the degree to which alternatives to litigation differ among themselves and with an action at law in the distribution of the severity of cases which they hear. The severity of actions at law are normally distributed. Data from the only arbitration plan for which enough quantitative information for analysis exists is not directly comparable to the actions at law, or the screening panels, for it represents settlements rather than decisions. It is apparent, however, that an injured claimant seeking to settle his grievance with the medical entity during the prearbitration settlement period is well advised to have an attorney represent him.

Physician screening panels differ markedly from the other methods of resolution in their attention paid to cases which they hear and decide. There is a strong tendency for them to hear more severe cases. By contrast, medical-legal screening panels hear cases whose percentage versus severity exhibits a tendency toward neither less severe nor more severe cases.

Malpractice Allegations Considered

The kinds of medical acts or omissions which gave rise to the claims studied in this report are presented in full in Appendix A. Some 75 specific kinds of medical errors are listed, from which the 2,420 cases studied arose. The information in this section sets forth a comparison of the ways in which the various resolution forums handle cases dealing with certain classifications of medical errors which produced the cases.

The large numbers of medical errors and their many sub-classifications present an interesting data base for further analysis; however, their discrete use cannot be applied to determine whether different types of claims are heard before the different forums due to the large number of event classifications and the relatively smaller number of cases heard by each kind of dispute resolution forum. However, simplifying the classification of medical errors into two broad categories—failure to diagnose and improper treatment—provides a productive framework for comparison of the cases heard by the plans studied. These classifications of improper treatment and failure to diagnose should not be confused with the familiar differentiation between acts and omissions significant in the law of torts.[19]

Although failure to diagnose generally constitutes an omission, improper treatment may be a series of interrelated acts and omissions. The distinction is a useful one in analyzing the kinds of cases which the dispute resolution forums hear, for failure to diagnose is more difficult to prove in an action at law. In general, if there is room for reasonable disagreement in applying professional judgment, the physician will prevail. The judgmental content of the art of diagnosis is generally greater than in prescribing treatment. Further, the standards against which diagnostic failures are weighed are more difficult of proof because the trail of evidence available to the plaintiff's attorney in proving his case is more difficult to find or reconstruct.[20] Conversely, once a disease or condition has been accurately diagnosed, there are more explicit standards of the profession available against which a breach of duty in treatment may be measured and proved.[21]

Figure 9 plots the ratio of failure to diagnose divided by the sum of failure to diagnose plus improper treatment allegations heard by each of five forums. Noted in the figure is that all of the forums, except the medical-legal screening panel in Pima County, Arizona, closely follow the same approximate values of this ratio. The cases heard by the Pima County screening panel involve a far larger proportion of the total cases involving an allegation of failure to diagnose. In fact, more than half the cases considered by the panel fell in this more abstruse category. This difference cannot be explained by the fact that diagnostic errors are committed only by physicians and not by allied personnel or hospitals because the data sources against which the Pima County ratio is compared to the other alternatives generally involve only allegations made against physicians.

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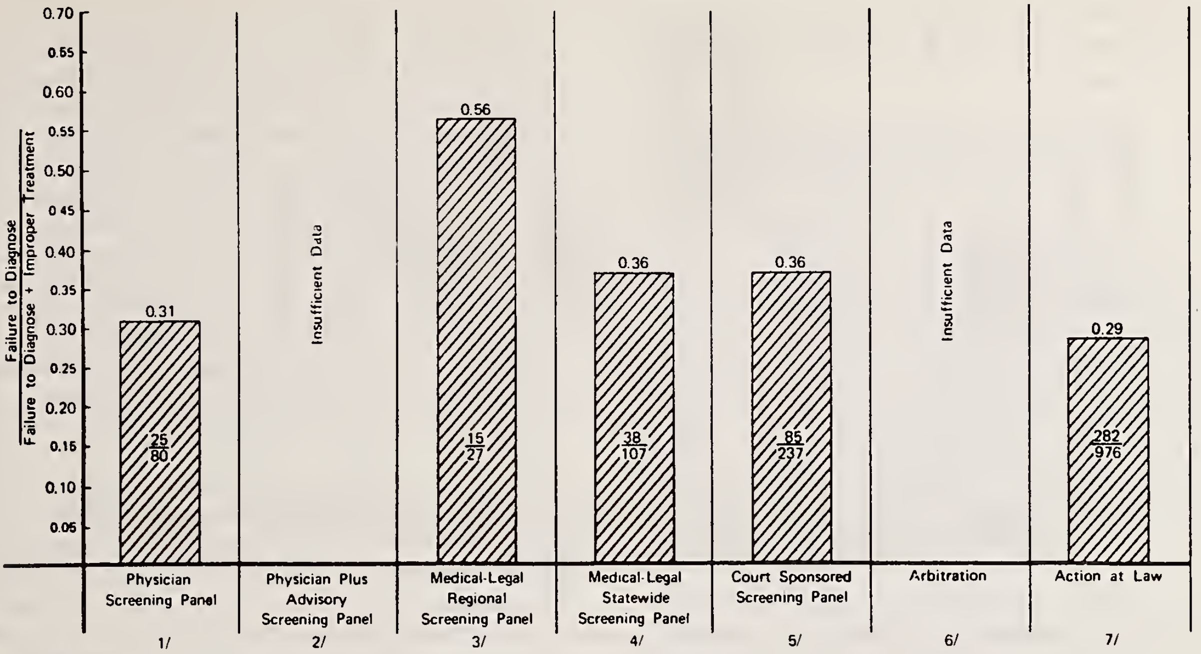
[19] For an interesting discussion of this distinction and its proper application, see generally, W. Prossner, *Law of Torts*, 3rd edition, St. Paul, Minnesota, West Publishing Company (1964), especially Section 54. Although the distinction is an ancient one, the *Restatement* speaks of "acts" and "duties of affirmative action". Sec *Restatement, Torts 2d*, secs. 5 and 13, topic 5.

[20] See, e.g., Kane, "Diagnostic Error May be Excusable But Negligence Never", *Modern Medicine* 144 (May, 1971).

[21] See, e.g., "They Can Sue If Your Treatment's Too Old", *Medical Economics* 102 (Feb, 1971).



Data Source:

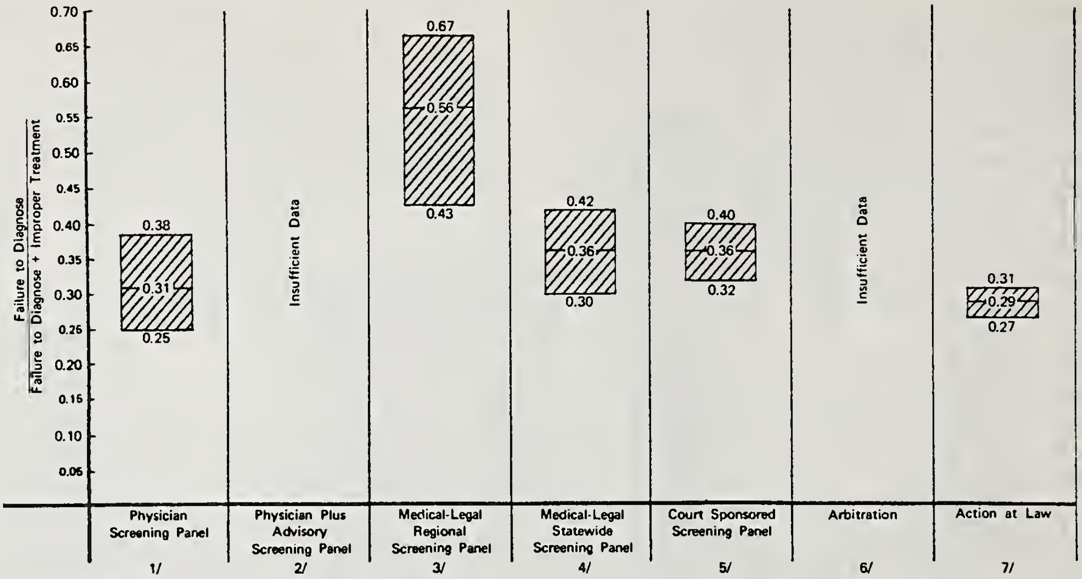
1. Medical Chirurgical Faculty of Maryland
2. King County (Washington) Screening Panel (Reported)
3. Pima County (Arizona) Medical-Legal Screening Panel
4. New Mexico
5. New Jersey
6. Ross-Loos Medical Group (3 Cases Arbitrated)
7. Jury Verdict Research, Inc. Data

FIGURE 9
CASE CHARACTERISTICS RATIO—DIAGNOSIS TO TOTAL ALLEGATIONS OF ERROR

The comparisons displayed in these case characteristics in terms of improper treatment and failure to diagnose are for all such data available in each of the five dispute reolution forums. The data or parameters, therefore, represent the entire population. If these observations, however, are viewed as a continuous process, then their observed results might be viewed as a continually increasing sample of an infinite population of the characteristics of cases heard. This concept would allow the case characteristics ratios to be considered a sample of this infinite population and variations due to sample size of the observed values can be calculated. This has been done in Figure 10, which presents the upper and lower 80% confidence levels computed about the observed values.

When the 80% upper and lower two-sided confidence intervals are examined, then the differing behavior of the Pima County medical-legal screening panel from that of the other dispute-resolution forums is even more apparent. This Pima County information about its screening panel, however, may be compared to several categories of screening panel use and with actions at law—all in Pima County.

Figure 11 breaks down the cases heard within Pima County, showing the ratio of failure to diagnose divided by the sum of failure to diagnose plus improper treatment cases. These categories within Pima County are for cases heard only by the screening panel, cases involving only actions at law, and cases which involve both the screening panel and actions at law as well. The figure contrasts the behavior of these alternative ways of solving disputes within Pima County; again, the striking characteristic of cases appearing before the screening panel is that it involves a far higher proportion of allegations of failure to diagnose. Shown in the left of the figure are the ratios, and in the right the upper and lower 80% confidence limits.



Data Source:

1. Medical Chirurgical Faculty of Maryland
2. King County (Washington) Screening Panel (Reported)
3. Pima County (Arizona) Medical-Legal Screening Panel
4. New Mexico
5. New Jersey
6. Ross-Loos Medical Group (3 Cases Arbitrated)
7. Jury Verdict Research, Inc. Data

FIGURE 10
80% UPPER AND LOWER CONFIDENCE LIMITS ON CASE CHARACTERISTICS RATIOS

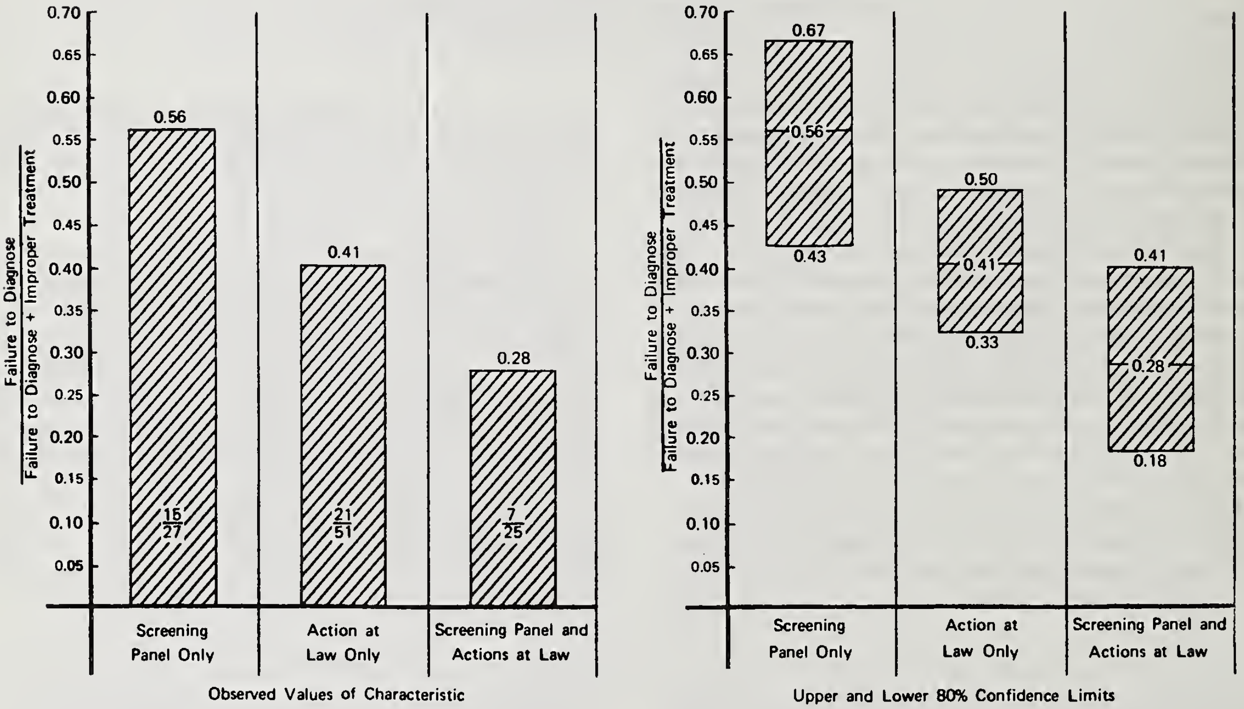


FIGURE 11
CASE CHARACTERISTICS RATIO AMONG PIMA COUNTY FORUM COMBINATIONS

From this behavior of the Pima County panel in the kinds of cases which it hears, it may be inferred that the screening panel hears a far higher proportion of cases which would be most difficult to prove at an action at law. This finding is perhaps indicative of the screening panels' ability to deal with a more sophisticated kind of medical malpractice case through its expert fact-finding body than either the other alternatives to litigation for which this data were available or than actions at law. It is equally probable that the cases which are more difficult to prove are brought by the claimant's attorney to the screening panel in hopes that a finding of liability will be established. This alternative explanation supports the contention of critics of the screening panels[22] that screening panels perhaps increase the number of what the critics characterize as "frivolous" claims.

The hearing by a medical-legal panel of a kind of claim which is difficult to prove (whether or not termed "frivolous") does not mean that this claim will find rewards simply as a result of that hearing. When all decisions of the Pima County screening panel are considered together (that is, both those disposed of by the screening panel alone and those in which decisions were rendered by the screening panel but also were pursued in an action at law), the following results are noted. Table 11 is a contingency table of screening panel findings for plaintiff and defendant versus cases heard by it in terms of allegations of failure to diagnose and improper treatment. Even though 0.34 of all decisions were for the plaintiff, it is apparent that the panel has the same difficulty as a jury in finding a physician negligent in cases alleging failure to diagnose, for that decision ratio in this class of case is only 0.15. This finding would seem to suggest that even if screening panels encourage the bringing of "frivolous" claims (or more properly, those claims which are based on facts involving a high degree of judgment by the physician), they are dealt with accordingly.

B. DIFFERENCES IN OUTCOME VERSUS RESOLUTION METHOD

Decision Ratios Versus Type of Plan

It is informative to note the comparative way in which the various alternative plans to litigation dispose of cases in favor of the plaintiff or defendant. For this purpose, although an imperfect measure of justice, the ratio of the number of decisions for the plaintiff to the total number of decisions was computed for plans for which such data was available. Figure 12 displays the results of this analysis, showing the decision ratios for six alternatives to litigation compared with a national aggregate decision ratio for actions at law from the data files of Jury Verdict Research, Inc.

The ratios were calculated based on the numbers of defendants for which decisions were made; that is, if two defendants were the subject of a case hearing and a split decision was rendered, under the rules of analysis the case would be scored as one decision for the plaintiff and one decision for the defendant. Likewise, multiple-defendant cases for either the plaintiff or the defendant were each counted as a single decision for or against each defendant. For example, if three defendants were the subject of a hearing and the forum found that all of them had been professionally negligent, the case would be scored as three plaintiff decisions. Only real parties in interest involved in the medically-related aspects of the cases were considered in the analysis.

Malpractice Allegation	Decisions by Panel for			Panel Decision Ratio
	Plaintiff	Defendant	Total	
Failure to Diagnose	2	11	13	$\frac{2}{13}$ = .15
Improper Treatment	10	12	22	$\frac{10}{22}$ = .45
Total	12	23	35	$\frac{12}{35}$ = .34

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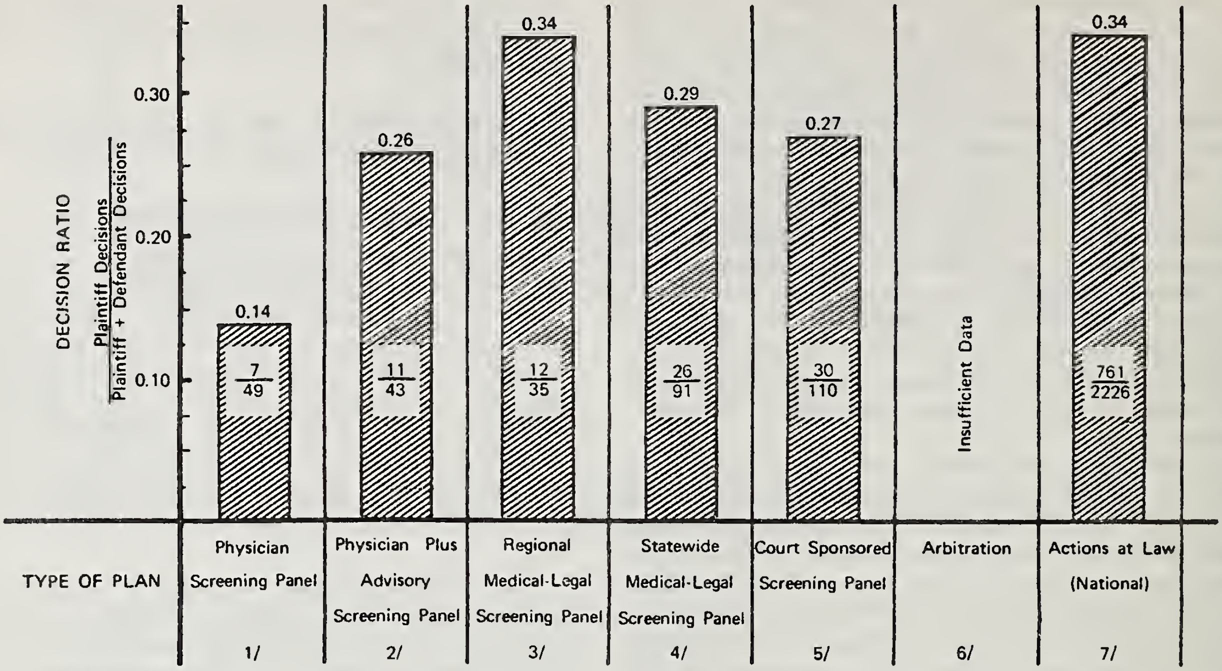
[22] The Medical Protective Company, "Pre-Trial Malpractice Screening Panels—A Commentary", Fort Wayne, Ind., (1970) Unpublished.



Data Source:

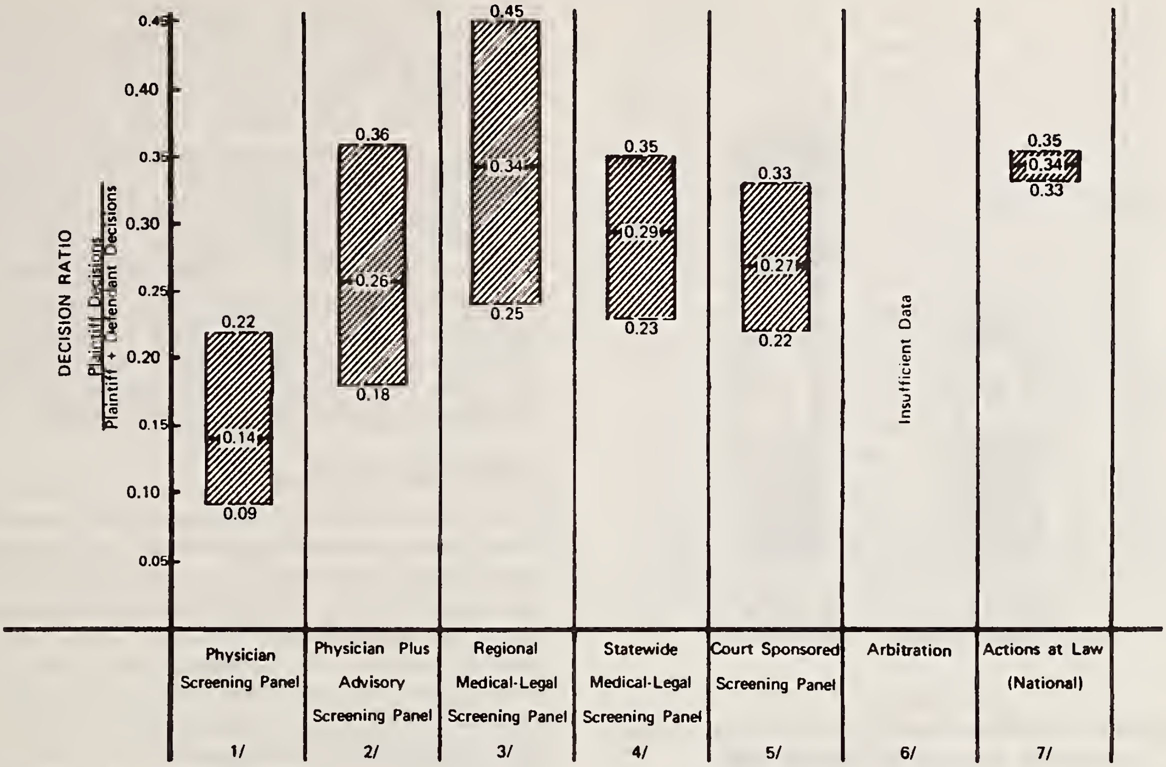
1. Medical Chirurgical Faculty of Maryland
2. King County (Washington) Screening Panel (Reported)
3. Pima County (Arizona) Medical-Legal Screening Panel
4. New Mexico
5. New Jersey
6. Ross-Loos Medical Group (3 Cases Arbitrated)
7. Jury Verdict Research, Inc. Data

FIGURE 12
DECISION RATIO VERSUS TYPE OF PLAN

The comparisons in the figure are significant in that they display the conclusions that, with the exception of physician screening panels, the alternatives to litigation find for the claimant in about the same ratio as do actions at law, and differ little among each other. The comparison with the actions at law, it should be noted, is on an overall basis and without adjustment for interjurisdictional differences in the decision ratios or types of defendants, which will be covered in more detail in relevant portions of this section.

The very low decision ratio noted in the table for the physician screening panel, the Medical Chirurgical Faculty of Maryland, can be explained by its stated purpose; that is, not to determine whether there was or was not professional liability in the particular case, but whether the case was defensible or nondefensible in an action at law. From the small number of data points available for comparing these decision ratios, however, the difference in the decisions of the Maryland physician panel might statistically occur by chance alone about half of the time, and the reader is left to make the value judgment whether the physician screening panel decisions more frequently favor physicians by chance or by choice.

The following further statistical tests of these data may prove illuminating, but the most accurate measurement of the data is always its observed value. The comparisons displayed in Figure 12 of decision ratios by type of plan are for all cases studied in the jurisdictions and therefore represent the entire population of known data. Where an entire body of data is observed, the observed value of any parameter of that data is the true value of that parameter. There is another way of looking at what this analysis has revealed, however. If these alternatives to litigation are viewed as a continuous process, then their observed results might be viewed as a continually increasing sample of an infinite population of decisions. This concept would allow each decision ratio to be considered a sample of the infinite population and variations expected due to sample size of the observed values can be calculated. This has been done in Figure 13, which presents the 80% confidence levels computed about the observed value for upper and lower two-sided confidence intervals. This calculation displayed in the figure gives a measure of the statistical variation of the decision ratio of the forum and represents the expected range of the decision ratio as the population increases. The upper and lower 80% confidence bands narrow as the sample size becomes larger, as can be noted in the right column of the figure for the "sample size" of 2,226 actions at law. What is significant is that when these decision-making bodies are viewed as a continuous process rather than as an aggregate body of decided cases, the application of confidence levels makes the behavior of most of them in reaching decisions for the plaintiff or defendant appear even more alike, but the physician screening panel still appears to favor physicians.



Data Source:

1. Medical Chirurgical Faculty of Maryland
2. King County (Washington) Screening Panel (Reported)
3. Pima County (Arizona) Medical-Legal Screening Panel
4. New Mexico
5. New Jersey
6. Ross-Loos Medical Group (3 Cases Arbitrated)
7. Jury Verdict Research, Inc. Data

FIGURE 13
UPPER AND LOWER 80% CONFIDENCE LIMITS
ABOUT DECISION RATIOS

Physician Screening Panel

The differing behavior of the physician screening panel with other alternatives to litigation and with actions at law deserves separate analysis. Shown in Figure 14 are the decision ratios for the Med-Chi Faculty of Maryland screening panel and the decision ratio for actions at law in Maryland, rather than for the overall national data base of actions at law as was'done in the preceding analysis of all plans.

Although the actions at law in Maryland have a higher decision ratio than the physicians screening panel, a Chi-Square test of significance reveals that this difference would be expected to occur by chance about half of the time. It is concluded, however, that this difference is probably not due to chance and that, because of its differing decision basis, the physician screening panel is far more apt, on the average, to find in favor of the physician than the other alternatives to litigation and the action at law. This conclusion is buttressed by the analysis of the severity of suits to which the Maryland physician screening panel devotes its attention.

Figure 15 adds the decision ratio versus severity to the percentage of suits versus severity shown previously, to demonstrate the differing case handling emphasis of this physician panel. Note that there is not only a greater emphasis on cases heard versus their severity but that the decision ratio varies with severity as well.

The lower line of the figure shows the panel's decision ratios plotted as a function of severity. As indicated in the figure, the Med-Chi screening panel devotes a greater proportion of its time and attention and more frequently finds for the claimant (or, more properly, decides to settle a claim) as case severity increases. This is perhaps because cases heard by the panel are in large part selected by a representative of its liability insurance carrier. This cooperation between the liability insurance carrier and the physician screening panel ensures that the interest of physicians in contesting or settling medical malpractice claims is not a unilateral decision by the insurance company. It also affords the insurance company with a ready answer to a medical society which complains about the increasing cost of medical-professional liability insur-

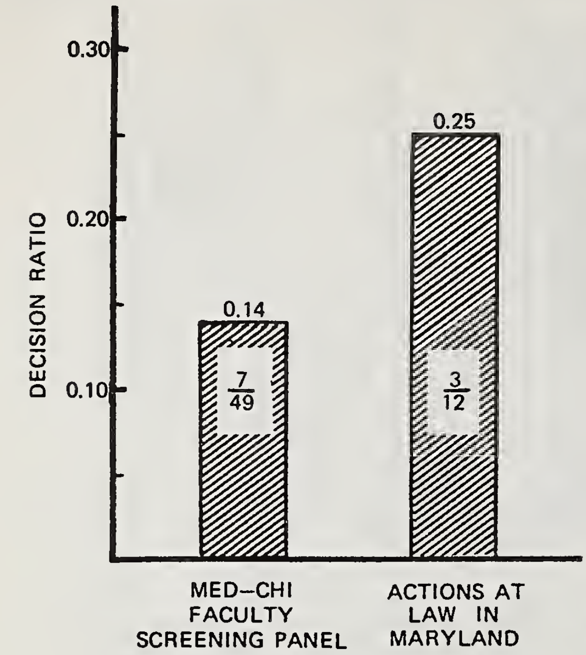


FIGURE 14
PHYSICIAN SCREENING PANEL AND ACTION AT LAW DECISION RATIOS IN MARYLAND

ance. This is because the physicians themselves act as the decision makers in determining which cases to defend or settle.

Physician-and-Advisory Screening Panel

Although the overall comparison of the decision ratios versus type of plan shown in Figure 12 indicates that the decision ratio of the physician-plus-advisory screening panel (0.26) was about the same as for actions at law (0.34), the conclusion is based on data reported by the King County (Washington) screening panel and was not independently verified by this study because records could not be made available. It is unlikely that the token representation of one member of the bar association could so markedly alter the decision ratio of the panel from that of the Maryland panel (0.14). The conclusion must therefore be viewed with caution until further research perhaps sheds light on whether the Maryland physician screening panel and the King County panel have underlying differences that could not be the subject of this study. The answer may lie in the way cases are selected by these panels, their degree of objectivity in decision making, or other factors.

Medical-Legal Screening Panel

The decision ratio (0.34) previously reported for the Pima County medical-legal screening panel included cases against defendants which had been considered by the screening panel only, and cases heard by the screening panel which also involved actions at law. Further, the comparison of this plan, and all others, with actions at law was made against the Jury Verdict Research, Inc., data which represents a large, but probably nonrepresentative, population of medical malpractice cases. Also, the JVR data is a composite of decisions for and against physicians and hospitals. As will be analyzed later in this report, this composite differs from its parts and is useful for only an overall approximate basis of comparison.

Fortunately, data with respect to decisions for the actions at law and for hearings by the screening panel were also available within Pima County alone. In addition, and

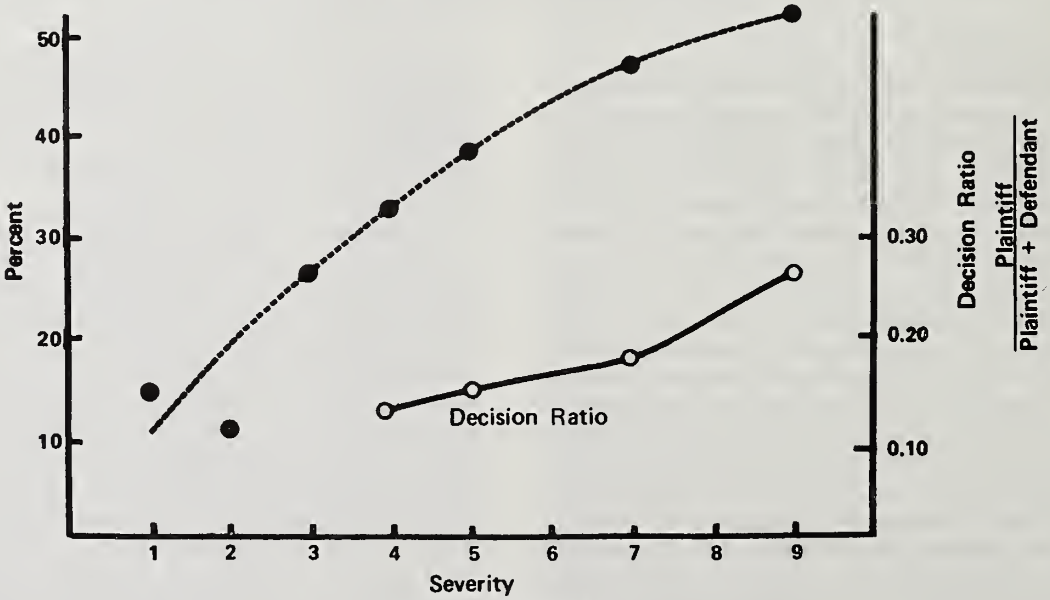


FIGURE 15
MARYLAND PHYSICIAN SCREENING PANEL—PERCENT OF CASES REVIEWED AND DECISION RATIO VERSUS SEVERITY

most fortuitous for the conduct of this study, information on medical malpractice actions at law in Maricopa County, Arizona, was also available and embraced about the same time frame as did the screening panel and action at law decisions in Pima County.

This subsection analyzes decisions by the Pima County screening panel and cases decided within Pima County involving actions at law, and compares their results with the decisions in actions at law in Maricopa County, Arizona, which had no screening panel.

Figure 16 shows the decision ratios for four classes of cases within Pima County. The two left bars of the figure indicate the decision ratios of the screening panel; the two right bars, the decision ratios in actions in law. The figure reveals that the screening panel cases, whether or not an action at law is involved, tend to find for the claimant a greater percentage of the time than the action at law. This finding, even from the small number of cases, lends credibility to the medical-legal screening panel as an institution in that it is indicative that it is by no means a procedure solely for the benefit of physicians.

Although data was available for only four decisions arising out of three cases which had involved both the screening panel and the action at law, the decisions by the screening panel proved to be either upheld by the action at law or (in one case) reversed in favor of the defendant. These results are tabulated in Figure 17, which shows the four decisions in actions at law for which the screening panel also rendered decisions, and how the decisions were determined in the action at law.

In one case, no decision was made by the screening panel, due to the pending of an action at law. In this case, the jury found for the defendant in the action at law. One case in which the screening panel decided that neither of two defendants was negligent was decided in a subsequent action at law for the defendants by directed verdict at the close of plaintiff's evidence. This action by the court in determining that the defendant need not be required to put on his evidence in defense for failure of the plaintiff to establish a prima facie case further upholds the integrity of the Pima County screening panel. In the fourth case, the screening panel held the defendant to be negli-

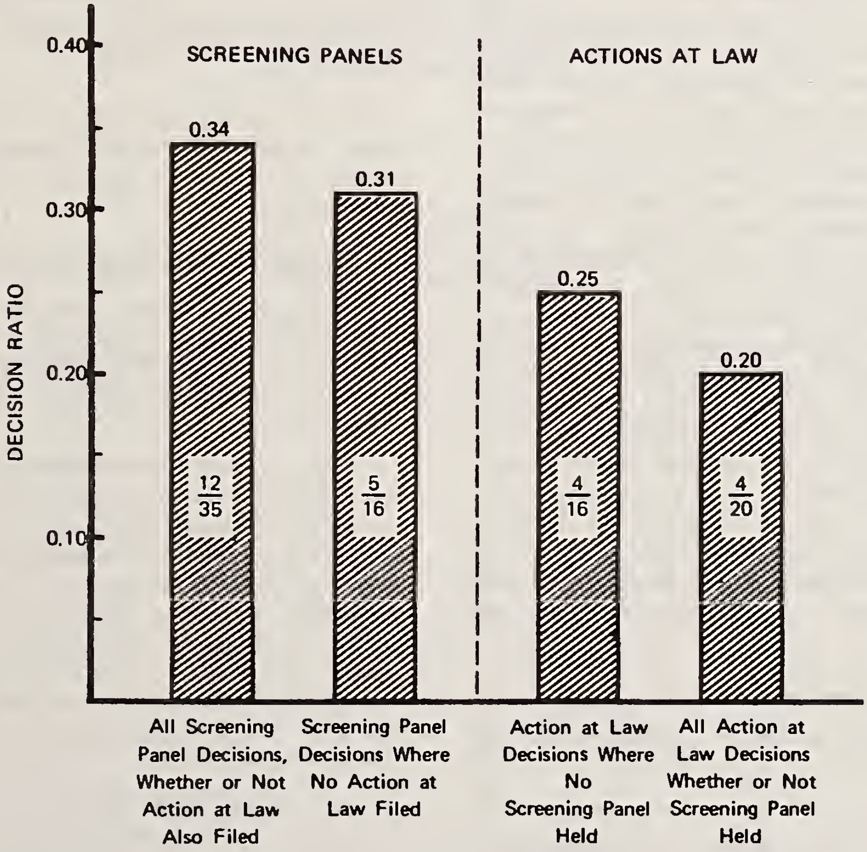


FIGURE 16
DECISION RATIOS IN SCREENING–PANEL/ACTION-AT-LAW
OPTIONS IN PIMA COUNTY, ARIZONA

Screening Panel Decision	Action at Law Decision	How Determined
None -- action at law pending	For defendant	By jury
For defendant	For defendant	Directed verdict
For defendant	For defendant	Directed verdict
For plaintiff	For defendant	By jury

FIGURE 17
COMPARISON OF SCREENING–PANEL AND ACTION-AT-LAW
DECISIONS IN THE SAME CASES, PIMA COUNTY

gent. However, the jury (unaware of the screening panel finding) awarded a verdict for the defendant. The last case, although only a single instance, indicates that the screening panel is on occasion even more severe in finding against physician defendants than a jury, and that the expert fact-finders of the screening panel may in fact find liability in an instance where a jury can be convinced there is none. It is fortunate that the screening panel has demonstrated its integrity in finding liability, but unfortunate that the defendant against whom the decision was rendered (or his insurance carrier) refused to effect reasonable settlement and required a subsequent trial at an action at law. This case is illustrative of many potential injustices in which the lack of finality of the decisions of a screening panel prevent a claimant from receiving compensation for damages. The case is also one in which a jury failed to reach a verdict identical to that of the experts. In this case, however, the result reached by the jury is the opposite of that generally attributed to juries by physicians who are critical of resolution of complex medical fact issues by laymen. The physician defendant undoubtedly feels that his innocence of wrongdoing was properly upheld in court and that he was justified in refusing settlement. The dichotomous results in this case illustrate the difficulty with which a system of compensation based on theories of legal fault or blameworthiness are to be reconciled with external or superordinate conceptions of right and wrong.[23]

Court-Sponsored Screening Panel

Two screening panels which are administered by the courts were studied. Only one, the New Jersey plan, had accumulated sufficient data for meaningful quantitative study of its decision ratio, shown in Figure 18. The values are not out of line with the decision ratios of actions at law (0.33) plotted for comparison in the figure. This is the decision ratio for all jury verdicts against physicians and surgeons who comprise the large majority of defendants before the New Jersey panel.

The New Jersey panel decision ratio data was the only source which permitted meaningful decision trend analysis. As shown in the figure, the decisions are relatively stable over time.

Differences in Case Disposition by Actions at Law

The preceding discussion has focused on the decision ratios of screening panels in their disposition of cases. There are also striking differences in the way cases are decided by actions at law, which are addressed in this subsection.

During the period for which data were collected (about five years), Pima County (Arizona) had the country's most active medical-legal screening panel. By contrast, its neighboring jurisdiction, Maricopa County, had none. The way in which these two jurisdictions handled and disposed of medical malpractice cases during this time provides a useful insight into what might be expected from the presence of a screening panel within a jurisdiction, and also is indicative of the way in which decisions in actions at law may be widely different even in circumstances where the substantive law and rules of procedure are the same.

Table 12 presents the decisions in actions at law for the plaintiff and the defendant in Pima County and Maricopa County. As shown in the table, a total of four decisions were granted for the plaintiff in Pima County and twelve for the defendant, for an overall decision ratio of 0.25. By contrast, the results in Maricopa County are three decisions for the plaintiff and thirty for the defendant, which produces a decision ratio of 0.09.

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[23] This study did not consider other compensation systems. See, e.g., F. McDowell, MD, "Rx for the Malpractice Plague: Workmen's Comp," *Medical Economics*, March, 1971, pp. 211-218; Institute for Interdisciplinary Studies, "No-Fault Medical Injury Sestem Feasibility Study," Minneapolis, Minn., 1972 (unpublished); C. Rosenberg, "Now They're Talking Up No-Fault Malpractice Coverage," *Medical Economics*, Oct., 1970, p. 165; D. Zinman, "'No-Fault' Medical Suits Eeed," *The Washington Post*, Mar. 19, 1971, p. E-1.

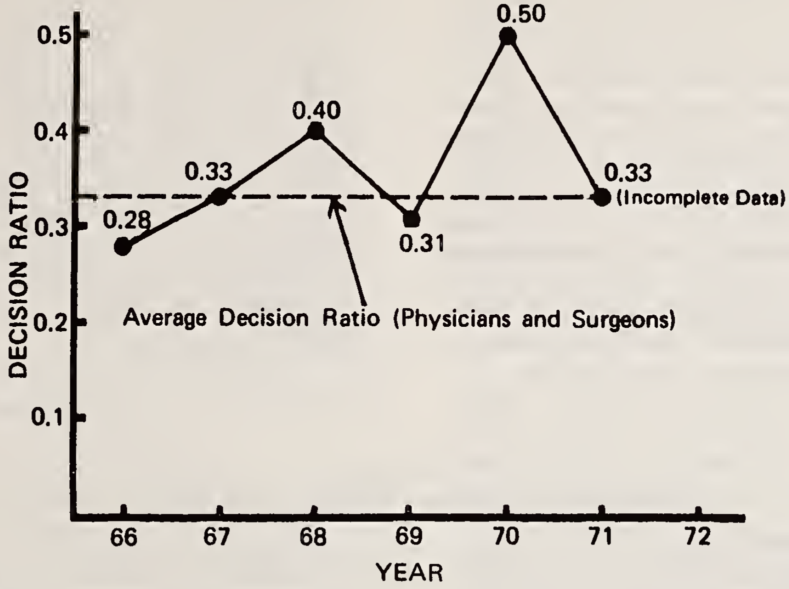

FIGURE 18
DECISION RATIO VERSUS TIME–NEW JERSEY COURT-SPONSORED
SCREENING PANEL

TABLE 12
TOTAL DECISIONS IN ACTIONS AT LAW IN TWO
ARIZONA COUNTIES

Decision and Method Reached	Pima County (78 Cases)	Maricopa County (78 Cases)
For Plaintiff		
Jury Verdict	4	2
Default	--	1
Total	4	3
For Defendant		
Jury Verdict	7	9
Summary Judgment	3	16
Directed Verdict	2	5
Total	12	30
Decision Ratio	$\frac{4}{4 + 12} = 0.25$	$\frac{3}{3 + 30} = 0.09$

From this striking difference in the overall decision ratio, however, it may not be inferred that there is something different about the way in which juries in the two counties view a medical malpractice action. Table 13 shows the comparison of the two counties with their respective jury findings for the plaintiff and defendant. A Chi-Square test of statistical significance was performed on the information shown in the table, and it was concluded that even though the Pima County decision ratio in cases decided by juries was 0.36 while that of Maricopa County was 0.18, this difference could be expected to appear by chance a high proportion of the time and that there is no significant difference between the two jurisdictions, on a statistical basis, in the which juries decide cases.

The difference in the overall decision ratios lies in the way in which the courts in Pima County and Maricopa County allow cases to reach the jury. Maricopa County exhibited a striking number of summary judgments when contrasted to Pima County (16 versus 3), and more than twice the number of directed verdicts (5 versus 2). This different behavior cannot be attributed to chance alone, as is shown in Table 14, which notes for each county the numbers of cases decided by the jury and cases in which decisions were rendered by the court. This difference is significant at the 0.95 level based on a Chi-Square test of statistical significance.

TABLE 13
JURY DECISIONS IN ACTIONS AT LAW IN TWO ARIZONA COUNTIES

Jury Decision	Pima County	Maricopa County	Total
Jury for Plaintiff	4	2	6
Jury for Defendant	7	9	16
Total	11	11	22
Decision Ratio	$\frac{4}{4+7} = 0.36$	$\frac{2}{2+9} = 0.18$	$\frac{6}{6+16} = 0.27$

TABLE 14
JURY AND COURT DECISIONS IN TWO ARIZONA COUNTIES

Decision Method	Pima County	Maricopa County	Total
Decisions by Jury	11	10	21
Decisions by Court	5	21	26
Total	16	31	47
Jury to Total	$\frac{11}{16} = 0.69$	$\frac{10}{31} = 0.32$	$\frac{21}{47} = 0.45$
Court to Total	$\frac{5}{16} = 0.31$	$\frac{21}{31} = 0.68$	$\frac{26}{47} = 0.55$

In general, a motion for summary judgment must be sustained on the ground that there is no genuine issue on any material fact, and that the moving party is entitled to judgment as a matter of law. The purpose of the motion is to achieve a quick resolution of the dispute when there is no necessity for a trial on the facts. One noted authority has stated that the motion is generally not popular with the courts.[24] This is because the summary judgment procedure, if erroneously applied, deprives a person of his right to a trial on the facts. Therefore, any reasonable doubt about whether or not there is an issue of fact is resolved against the party seeking summary judgment. Despite this most stringent test upon which summary judgment is granted, the court in Maricopa County rendered more than half its decisions on this basis. By contrast, summary judgment was granted in Pima County on less than one-fifth of all decisions.

The answer as to the differing behavior of the Pima County and Maricopa County courts may lie in two dimensions. The most attractive explanation would be that the existence of the screening panel in Pima County eliminates from the docket the nonmeritorious or "frivolous" medical malpractice claims. However, there is one important difference in the operation of the two court systems which, it is concluded, may explain this differing behavior more adequately and, within the realm of alternatives to litigation, provides even greater insight than would the screening panel explanation alone. A number of judges and court administrators in Arizona were contacted, and the following picture of the two court systems emerged.

In Pima County, cases are assigned to any judge who, on that day, may be hearing either trials or motions; this is the so-called "master calendar system." Throughout the litigation of cases under this method of judge assignments, preliminary motions may be heard and disposed of by a number of judges. The system of master calendaring of cases has been criticized in recent years, for it is suggested that no judge is particularly responsible for court backlog but the blame is shared only institutionally. A second criticism of a master calendar system is that the availability of different judges to hear differing facets of the litigation leads to "judge shopping" by some attorneys. In an exercise of its supervisory power over the inferior courts of Arizona, the Arizona Supreme Court adopted a rule applying (in effect) to Maricopa County alone, requiring it to adopt a system of "individual calendaring". This means that from the time a case enters the court and requires judicial attention, it is assigned to a single judge who stays with the case from its inception to resolution. Both the master calendar and individual calendar systems, however, accommodate a change of judge upon motion of either party for good cause shown.

The individual calendar system provides two ingredients which might lead judges to more frequently grant summary judgment in a case. The case backlog of the particular judge is known to him and is more likely to inject a personal responsibility for court backlog into the judge's handling of the case; and second, the judge, having heard all preliminary motions and the like, is more familiar with the particular case and better able to deal with a procedure like summary judgment which requires extensive knowledge of the case to adequately and justly rule on its merits.

A well-documented rationale for this summary and speedy resolution of medical malpractice cases was presented before the National Conference of State Trial Judges in 1964 in a paper by a Superior Court judge from Seattle, Washington.[25]

This extensive use of summary judgment and directed verdicts in the resolution of medical malpractice cases may be considered almost of the dimensions of a further "alternative to litigation." If the use of this extraordinary procedure by the Maricopa County court was based on efficient judicial administration only and not on concern with a personal record of case backlog, an arbitrary decision that there was no genuine fact issue, or pro-physician judicial bais,[26] then it represents either a noteworthy efficiency in the resolution of medical malpractice claims or a serious deprivation of the fundamental right to trial.

Speed and Administrative Efficiency

Many time intervals were obtained from the case-by-case analysis of closed claims included in the data bank. One dimension of administrative efficiency is the dispatch with which a particular dispute resolution system deals with a claim once its existence is recognized. This subsection analyzes claims resolution by alternatives to litigation and actions at law in terms of speed and administrative efficiency. Several dimensions are considered in the analysis.

The totality of dispute resolution may be divided into several phases, all of which consume time from the perspective of the patient who is seeking compensation for his injury, the physician who may be wrongfully accused of committing an act of medical malpractice, and the insurance company which is seeking to determine an actuarial basis for premiums charged.

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[24] Levine and Horning, *Manual of Federal Practice* (New York, McGraw-Hill, 1967) section 4.35.

[25] E. Wright, "The Trial Judge: His Responsibility in Medical Malpractice Cases," 503 *Insurance Law Journal* 736 (December 1964).

[26] Plaintiffs' attorneys having a significant medical malpractice case volume interviewed frequently advanced the opinion that judges exhibit pro-physician bias. The rationale given for this was frequent upper-strata social contact, physicians in the judges' families, or joint financial investments. See "The Medical Malpractice Legal System," Supra, pp. 87 ff.

The analysis of dispute resolution in the paragraphs which follow is divided into several phases:

- *Incident to Recognition of Injury.* This dimension of dispute resolution is external to any of the formal methods of resolving claims. It is, however, an important dimension in the overall hypotheses stated about the medical malpractice phenomenon.

There is a rule of law in many jurisdictions which holds that the statute of limitations begins to run upon the recognition of an injury rather than from the negligent act which produced it. Many physicians and insurance companies contend that this is grossly unfair to them and results in their being confronted with many stale claims.

- *Incident or Recognition to Presentation for Resolution.* This time interval stems from the need for the patient to seek an attorney and the need for the claimant's attorney to adequately assess and prepare his case for presentation to the forum which will render a decision.

Many jurisdictions have different statutes of limitation before the expiration of which a legal action must be filed if it is to be filed at all. However, there is also a propensity on the part of attorneys to delay filing an action at law until they are sure that a case cannot be informally settled without formal legal action, or to use the full amount of time afforded by the statute for investigation or complete ascertainment of the claimant's legal damages. In addition, many attorneys are overworked and tend to delay seeking formal resolution until they absolutely are required to do so.

- *Formal Filing to Formal Hearing.* This time dimension, a part of the overall resolution process, represents the administrative efficiency of the formal machinery by which a medical malpractice dispute may be resolved.

It is important to note that in the overall dispute resolution process this may be only a small portion of the total time required to dispose of the claim. However, it does represent one part of the resolution process which can be adjusted to the needs of society and one which can be quantitatively presented in comparative analyses among the various alternatives to litigation and the action at law.

- *Formal Hearing to Resolution.* This interval of time is also external to the formal mechanism of dispute resolution. It embraces the negotiation strategy of the parties to the dispute and cannot, in general, be controlled by external means.

Incident to Recognition of Injury

Data from four jurisdictions are plotted in Figure 19 which displays the cumulative percentage of cases versus time in months from the incident to recognition of injury. As noted in the figure, the cases analyzed reveal that there is no merit in the proposition advanced (principally by the insurance industry) that there is a long "tail" in injury recognition for a significant number of claims. At least half of the claims are recognized either immediately or within one month of the incident which produced them. Only in Pima County was there a significant time delay (about 36 months) in recognition of the 90th percentile of claims.

It is concluded from this analysis that the essential element of the problem of actuarial computation casued by a delay in incident-to-injury recognition has been overemphasized and that the problem of delay, if any, lies in other phases of the resolution process.

Recognition of Injury to Action at Law

Figure 20 plots for two Arizona counties, Maricopa and Pima, the time interval from injury recognition to initiation of the action at law versus the percentage of total claims submitted to actions at law. The Arizona two-year statute of limitations for tort and wrongful death cases is also shown in the figure. The figure indicates that there is a propensity on the part of the attorneys to delay filing actions at law until the statute of limitations is about to expire.

This delay in filing an action at law was most notable in Maricopa County, where there was no screening panel during the period of time over which data was collected. By contrast, the data from Pima County indicates that claims are brought to actions at law without the sharp peak as the statutes of limitation are about to expire. As previously discussed, the reason for this could be the existence of the screening panel or the propensity of the courts in Maricopa County to grant summary judgments.

The small percentage of claims shown in the figure which are filed after the nominal two-year Arizona statutes of limitation for torts and wrongful death claims are perhaps those based either on a contract theory of recovery (which has a longer statute of limitations) or are cases brought in behalf of plaintiffs suffering a legal disability at the time their injury was recognized (against whom the statute of limitations would not run). For example, in the event of injury to an infant, the statute of limitations would not begin to run until attainment of the infant's majority.

Injury Recognition to Screening Panel Filing

Data for three representative types of screening panels are plotted in Figure 21, to display the cumulative percentage of claims filed versus time in months from injury recognition. The New Mexico screening panel and Pima County screening panel are medical-legal plans, while the New Jersey screening panel is administered by the courts of New Jersey. The figure reveals that claims are filed much sooner before the two screening panels which operate externally to the judicial system. For example, the median, or 50th percentile of claims, is filed before the voluntary medical-legal screening panels about seven months earlier than before the court-sponsored screening panel. The data plotted in the figure is indicative of the ability of extra-judicial plans to operate with greater dispatch in this one facet of claim resolution than those

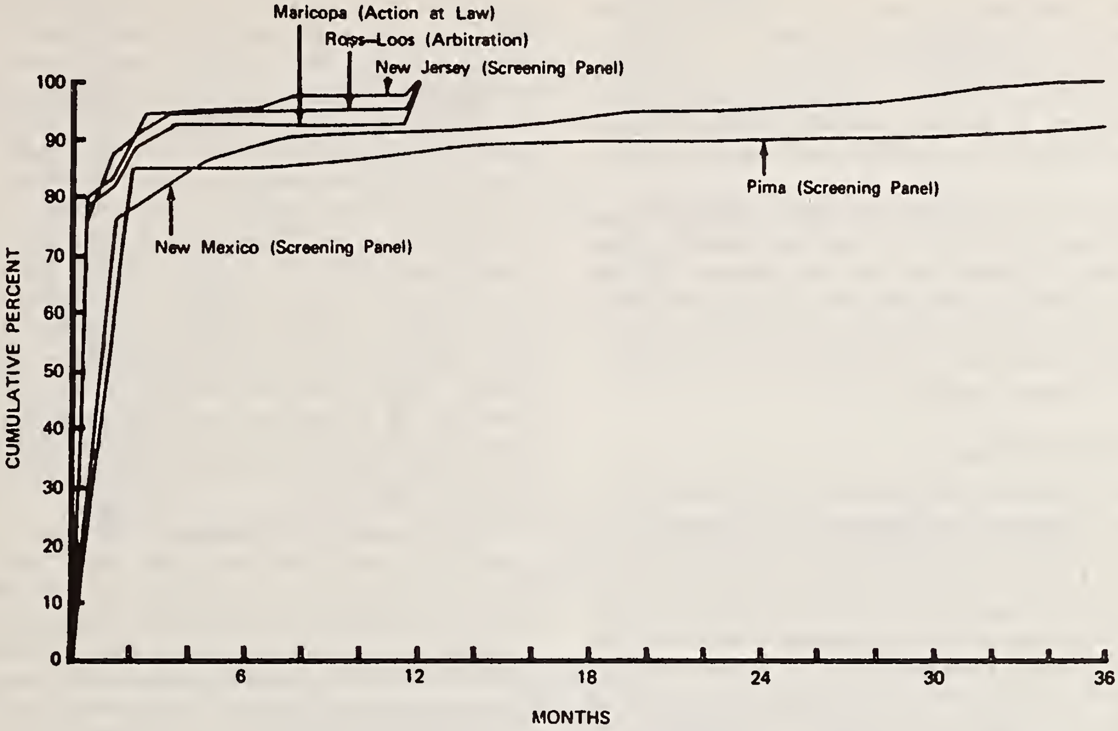


FIGURE 19
INTERVAL FROM INCIDENT TO RECOGNITION OF INJURY

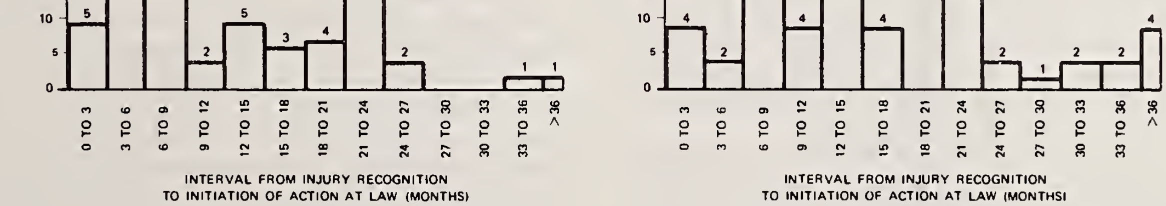


FIGURE 20
INJURY RECOGNITION TO FILING ACTIONS AT LAW
IN TWO ARIZONA COUNTIES

plans which are embodied within the judicial mechanism. This is perhaps due more to the fact that in the court-sponsored screening panel the claim has undergone most of the formal attributes of an action at law by the time the screening panel filing is made. Court-sponsored plans, in practice, focus their emphasis on reducing trials rather than actions at law, which is their greatest inherent limitation.

Although the New Mexico screening panel seems to display a greater efficiency in operation than the Pima County panel, no reason for this is apparent. It may simply be the result of the small body of data from which this conclusion is drawn, rather than any real differences in the tendency for claims to be filed sooner in New Mexico than in Pima County, Arizona.

Formal Filing to Hearing

The major ingredient under the control of administrators of dispute resolution mechanisms is the dispatch with which a hearing is granted from the date of submission to the forum. Data from the New Mexico and Pima County medical-legal screening panels and the New Jersey court-sponsored screening panel are contrasted with similar data for actions at law in Pima and Maricopa Counties in Figure 22, which shows the cumulative percentages of cases heard versus time in months after filing. As indicated in the figure, the time from filing to hearing at the median (or 50th percentile) of cases heard is about one year longer for actions at law than for screening panels, on the average. It is also apparent from the figure that none of the screening panels deal with claims with the dispatch which their published rules indicate (from 30 to 45 days).

At the 90th percentile of claims heard (after submission to the forum), the difference between screening panels and actions at law is even more marked. On the average, this 90th percentile is achieved by actions at law a year and a half later than by the screening panels. It is also apparent that the New Mexico screening panel deals with claims with greater dispatch than do the Pima County and New Jersey panels. At the 50th percentile, the New Mexico panel is about three months faster than the other two panels; and at the 90th percentile, about six months faster. In addition, the New Mexico panel disposed of all of its cases within one year of their filing, whereas both the New Jersey and Pima County panels required slightly more than two years to hear all cases. This difference between the New Mexico panel and other screening panels is perhaps explained by a greater administrative inflexibility of the New Mexico panel, as will be discussed in a subsequent section of the report dealing with the analysis of rules of the plans, together with the fact that it is actively administered by the medical society.

There is a need for explanation of the apparently greater speed with which the New Jersey panel hears cases as contrasted with the medical-legal panel in Pima County. One would infer that the Pima County plan (operating externally to the court mechanism) should be faster since it is not hampered by the administrative delay inherent in the court bureaucracy. This may be because a vast majority of cases heard by the New Jersey panel stem from actions at law already filed, where all preliminary investigation of the claim has already been accomplished at the time the request for panel hearing is made. By contrast, the Pima County plan provides for the claim investigation phase after the claim is filed. In this respect, the Pima plan is unique in that an expert witness is provided to the claimant to assist the attorney in preparing his case for the screening panel.

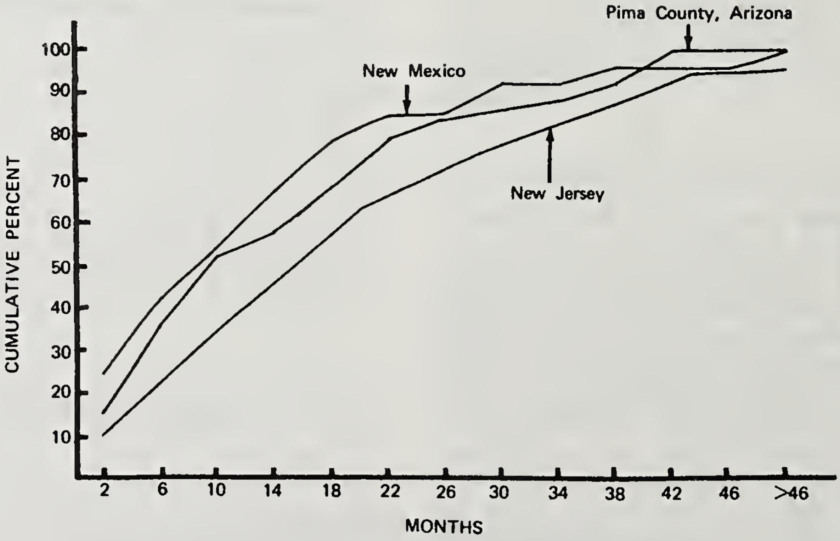


FIGURE 21
INJURY RECOGNITION TO SCREENING PANEL FILING

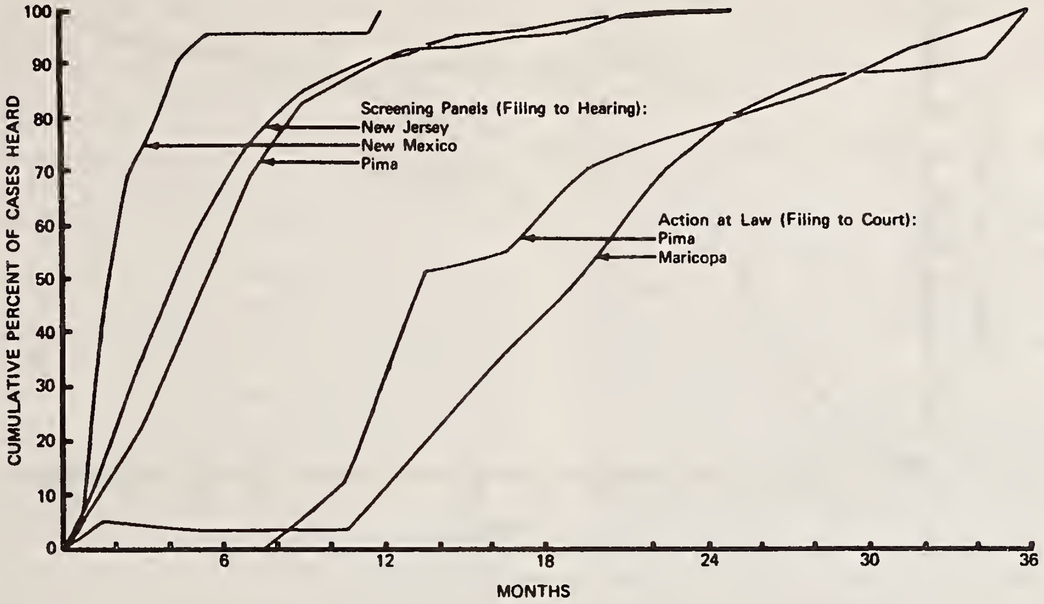


FIGURE 22
INTERVAL BETWEEN FILING AND FORMAL HEARING—
SCREENING PANELS VERSUS ACTIONS AT LAW

One noteworthy difference in the cumulative percentage versus time disposition of claims in the Pima and Maricopa County court systems is also shown in the figure. Maricopa County almost immediately resolves about five percent of its claims, which is shown by the behavior of the curve for Maricopa actions at law which quickly jumps to about five percent and then remains flat until approximately ten months have elapsed. This behavior is perhaps explained by the propensity of the Maricopa County court to grant summary judgments, as was analyzed in a preceding portion of this section.

The activity of the two court systems (Pima and Maricopa) in reaching the hearing stage in the claims resolution process indicates that claims are heard on their merits approximately two to three months faster in Pima County, probably due to a shorter docket delay within that jurisdication as contrasted with the courts in Maricopa County. At the 50th percentile of cases heard in the two jurisdictions, Pima County is faster by about six months. After this period of time, the difference in the actions at law filing-to-hearing dates between these two neighboring court systems narrows, and is about the same at the 90th percentile. Both court systems resolve all of the claims submitted to them in about three years.

One area of intriguing contrast between the various alternatives to litigation is the manner in which a medical-legal panel addresses cases as contrasted to a physician screening panel. Plotted in Figure 23 is the cumulative percentage of cases, from incident to hearing, versus time for the Pima County medical-legal screening panel and the Med-Chi Faculty of Maryland physician screening panel.

Noted in the figure is the greater dispatch with which the medical-legal panel hears claims as contrasted to the physician screening panel. This difference may be explained by the analysis presented previously as to how these differing mechanisms for dispute resolution decide which cases they will accept for processing. The Med-Chi Faculty of Maryland devotes a greater proportion of its energies to hearing claims of greater severity, which perhaps are more thoroughly investigated prior to the hearing. Also, the physician panel seeks only to reach a decision whether to settle or contest a claim rather than primarily to prevent claims from being filed or to settle just claims without putting the plaintiff to the test of trial. By contrast, the medical-legal screening panels appear to devote their attention to claims which do not significantly differ from actions at law in their severity distribution.

Overall Time From Incident to Verdict or Hearing

Even considering the previously discussed differing elements of case processing behavior by elements external to the resolution mechanism and those over which administrators have control, the important operative effect of all these dispute resolution mechanisms is the time required to resolve the claim. Figure 24 plots the time from incident to verdict or hearing of the dispute resolution mechanism versus the cumulative percentage of cases.

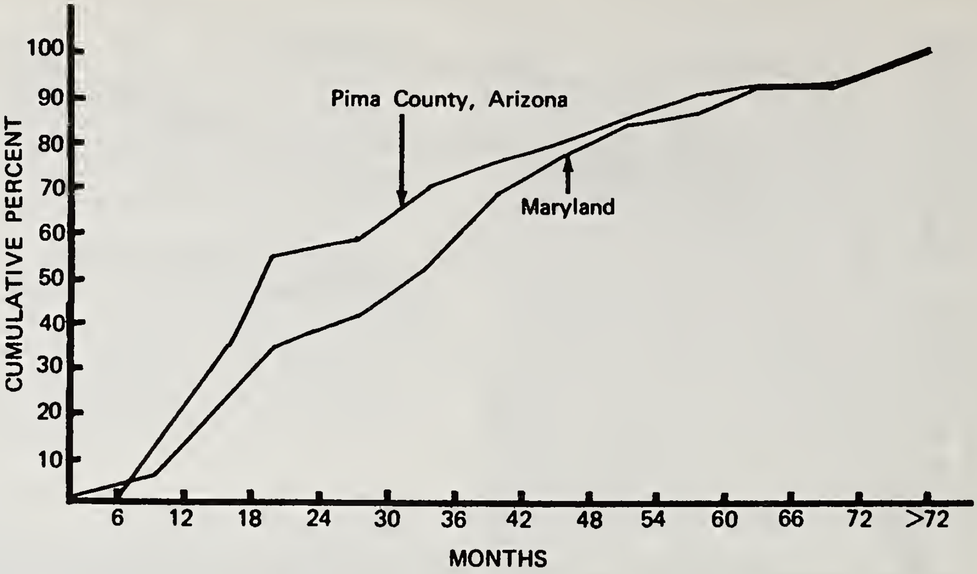
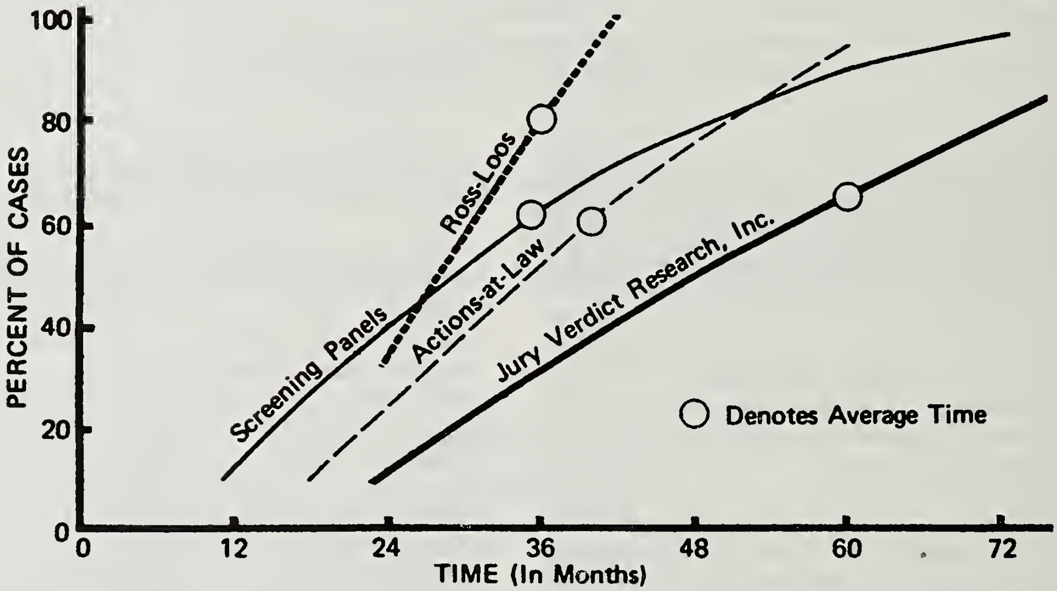


FIGURE 23
INTERVAL FROM INCIDENT TO HEARING—MEDICAL-LEGAL
VERSUS PHYSICIAN SCREENING PANELS



Key	Type of Forum	No Pts.	Avg Time (mo.)	Med Time (mo.)	90th Percentile (mo.)
········	Arbitration	3	36	—	39
——	Screening Panels	261	35	30	60
— —	Action at Law	37	40	35	55
━━	Action at Law (Jury Verdict)	421	60	48	82

FIGURE 24
INTERVAL FROM INCIDENT TO DECISION—SUMMARY OF PLANS

The figure is an important one, for it allows a comparison among the different malpractice resolution methods studied, in terms of the elapsed time between the date of injury (incident) and the date of the screening panel hearing or court verdict. The distribution of time-to-hearing (or verdict) in each case is skewed to the right, indicative of its log-normal characteristic, by the relatively few cases which required an extraordinarily long time to reach a decision. Individual plans are discussed in the following paragraphs.

The curve for the Ross-Loos arbitration procedure is based on the only three cases for which data was available (one point at 24 months and two points at approximately 42 months). The data is not sufficient for statistically meaningful point estimates of median and 90th percentile values, although the observed average time to hearing for the three cases was 36 months, comparable to the average time required by screening panels as a class.

The combined data from four screening panels studied is also shown. These were plotted individually and discussed in previous subsections. Data was available for a total of 261 panel cases. On the average, 35 months elapsed between occurrence of the incident and the screening panel hearing. Half of the cases were heard within 30 months—i.e., a median time to hearing of 30 months. Of all cases, 90% were heard within 60 months.

The third curve relates to 37 action-at-law cases studied in three jurisdictions (Pima County, Maricopa County, and Maryland). There was no material difference in times to verdict among the individual jurisdictions. Combined, the average elapsed time between incident and verdict was 40 months. Half of all cases obtained a verdict within 35 months; and in 90% of the cases, within 55 months.

Conclusions

It can be concluded from the preceding analysis that the time to resolve a medical malpractice dispute by existing formal methods is extraordinarily long, from the perspective of the negligently injured patient and the wrongfully accused physician. In addition, the fact that only 50% of cases are resolved within two to four years by the fastest to the slowest of these methods indicates that the actuarial problem in computing insurance premiums is indeed made difficult by the inherent slowness of claims resolution. Whether this process is slower for medical malpractice cases or cases of personal injuries arising from other causes would be a productive area of further research.

Although the data reported for arbitration indicates that the median time to settlement is slightly shorter than the two years required for screening panels, the average time is about one month longer and very little can be attributed in this analysis to conclusive comparisons of arbitration with the other methods, for the data is from only three cases. Of greater significance in assessing the reported speed of arbitration is the absence of a single arbitrated case in the Southern California Hospital arbitration experiment after that plan has been in effect for about five years.

The most dramatic and unrecognized mechanism of any studied was the significant use of summary judgment in the Maricopa County courts. Even this method, however, did not dispose of a majority of the entire body of claims filed in that jurisdiction.

C. SETTLEMENT STRATEGIES IN ACTIONS AT LAW

From the large body of litigated cases from the files of Jury Verdict Research, Inc., a substantial number contained information about the plaintiff's final demand and the defendant's final offer immediately before trial. In addition, the cases contain the amounts awarded by juries when the plaintiff prevailed.

Since case severity could be determined for each of these cases, it was possible to compute combinations of decision ratios, severity, demand, offer, and verdict for a large number of decisions. In the analysis which follows, these variables are analyzed to indicate the probable reasons for litigating rather than settling medical malpractice cases. It is concluded from the analysis that attorneys for both the plaintiff and the defendant have a remarkable grasp for their chances of winning a particular case and are also able to estimate with accuracy the economic worth of the cases.

It should be noted that the analysis which follows is based only on cases tried, or conversely, on cases in which no settlement was reached. This dissimilarity between demand and offer can be viewed as the quantitative measure of the parties' differences which prevented settlement and necessitated a trial.

Decision Ratios Versus Severity

It has been postulated that in actions at law, juries frequently find liability based on the severity of the plaintiff's injury, where in law there should be none. This specific attribute of juries has been advanced as one of the more serious deficiencies in the present jury system. Figure 25 tests this hypothesis and arrays decision ratios versus severity for all cases, cases against physicians, and cases against hospitals.

The figure shows that the aggregate jury decisions do increase for the plaintiff as a function of severity. However, the two major subcomponents of the aggregate plot—the decision ratio against physicians and against hospitals—tend to suggest that jurors are more frequently compelled to find liability against hospitals than against physicians, as a function of severity.

It should be noted that the data arrayed in Figure 25 shows the results of a large body of cases, and the underlying legal merits of the cases cannot be evaluated. Whether the juries are in fact finding liability as injuries become more severe cannot be determined conclusively from the data. However, the figure suggests that jurors do react to severity, if one assumes that, from a large body of litigated cases, the question of liability is independent of severity. The converse of this hypothesis—that medical entities are more blameworthy in cases where injuries are more severe than in cases where they are

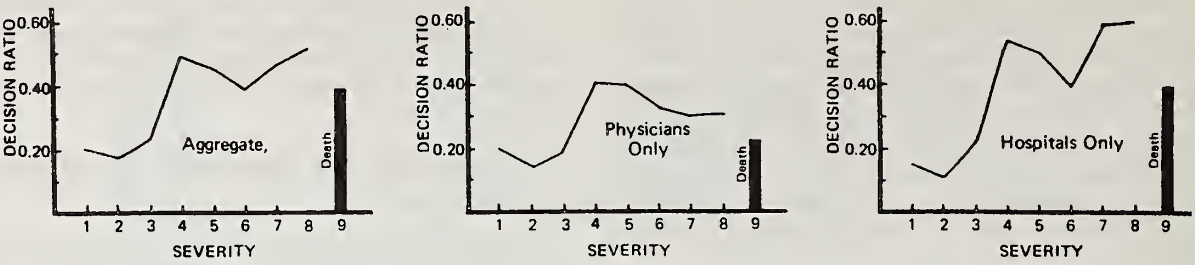


FIGURE 25
DECISION RATIOS VERSUS SEVERITY (SOURCE:
JURY VERDICT RESEARCH, INC.)

less severe—seems less likely than the proposition that jurors, in fact, find liability from sympathy. Further, there appears to be a greater propensity for jurors to find liability as severity increases in cases against hospitals than against physicians. This suggests more strongly that sympathy plays a large role, for the sympathy for the patient is apparently tempered by that for the physician, and the impersonal institution evokes none.

Results of Economic Analysis

For the body of data analyzed, the decision ratios as a function of severity against hospitals and physicians are used in the following analysis to compare demand, offer, verdict, and expected value in plaintiff and defense decisions regarding hospitals and physicians.

The expected values shown in the figures which follow are computed as:

$$E_s = R_s \times V_s$$

where E_s = expected value of recovery at a given severity

R_s = decision ratio at a given severity, computed as:

$$\frac{\text{Plaintiff Decisions}}{\text{Plaintiff Decisions} + \text{Defendant Decisions}}$$

V_s = average verdict at a given severity

The expected value, therefore, is the amount which (in the long run) should be recovered by plaintiffs, on the average, if the same cases were litigated many times.

Plaintiff Verdicts Against Hospitals

Figure 26 shows the behavior of these four functions (demand, offer, verdict, and expected value) as they vary with severity for a large number of plaintiffs' verdicts against hospitals. Noted in the figure are the increasing verdicts awarded as a function of severity. This analysis includes step 9 (wrongful death) in the severity scale in which allowable awards are frequently fixed by statute and which are economically less severe than critical injuries where, for example, a plaintiff may require lifelong extensive medical care. The plaintiff's demand is shown to closely follow the expected value curve rather than the amount which juries are seen to award. However, the defendant's offer curve, although somewhat closely paralleling the expected value curve through severity step 6, departs from it at severities above that range. This departure may be due to a small number of data points available in the analysis or perhaps due to defense attorneys' rationale that when awesome damages may be awarded, there is very little to gain by offering settlement in large amounts, and the highest payoff comes from taking the case to trial.

Defense Verdicts for Hospitals

In contrast to the previous figure which included only cases decided for the plaintiff, Figure 27 shows the same behavior of the demand, offer, and expected value for cases decided in favor or the defendant hospital. Since these cases were verdicts for the defendant, the verdict awarded is always zero and is not plotted. The plot indicates that the plaintiff's demand very closely approximates the expected value curve; however, the defense's final offer is far below that shown in the previous figure where verdicts were awarded to the plaintiff. This suggests that attorneys for the defense have an excellent understanding of their chances of prevailing at trial and are less likely to increase their offers if they feel they probably will win.

Plaintiff Verdicts Against Physicians

During the previous examination of decision ratios as a function of severity, Figure 25 showed that when a case is against a physician, juries less frequently decide in favor of the plaintiff as a function of increasing severity. Shown in Figure 28 are the demand, offer, verdict, and expected value where verdicts were awarded against physicians. In this case, the behavior of the attorneys is more strikingly continuous as they are seen to assess the relative merits of this class of cases over the range of severities. The defendant's final offer almost completely follows the expected value curve. Conversely, the plaintiff's final demand is always greater than the expected value curve, but

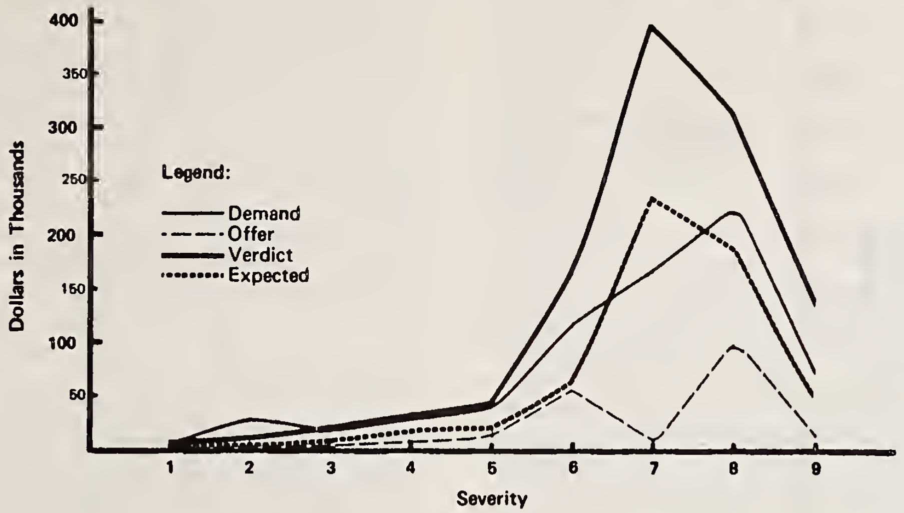


FIGURE 26
PLAINTIFF VERDICTS AGAINST HOSPITALS

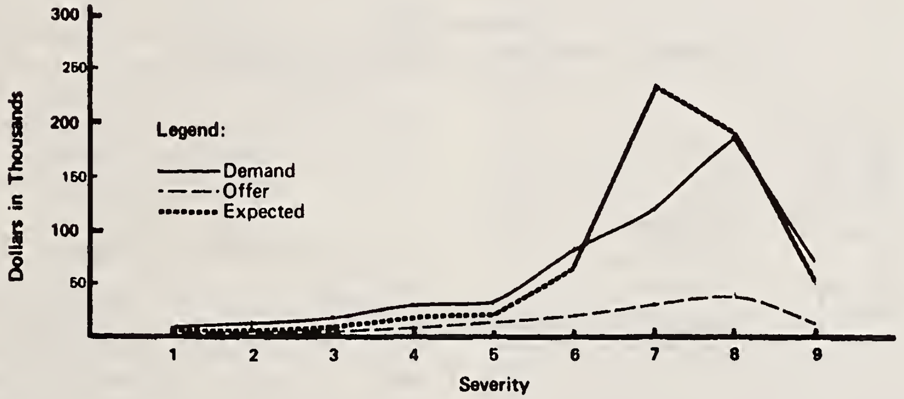


FIGURE 27
DEFENDANT VERDICT FOR HOSPITALS

for cases involving high severity, the demand comes close to it. This suggests that attorneys for both the plaintiff and the defense understand the way a jury is likely to react to the many cases litigated and analyzed.

It is significant that the plaintiff's final demand for high severity cases does not depart far from the expected value but moves more nearly toward what juries are seen willing to award in the lower severity cases, shown by comparing the verdict and demand curves in the figure. This is perhaps because in high severity cases, the risk of losing the case far outweighs the substantial final demand if the demand has been accepted. The inability to settle these cases can be considered as the difference between the demand and offer curves. It is interesting to note that for low and high severity cases the plaintiff and defense attorneys appear closer together in their demands and offers than they do for cases of mid-range severity. This would suggest that harder negotiation or a greater willingness for give and take would be more productive in the lower severity cases.

Defense Verdicts for Physicians

By contrast to the preceding figure, which shows cases in which the jury awarded its verdict in favor of the plaintiff, Figure 29 portrays the demand, offer, and expected value of cases in which the jury returned its verdict for the defense. Again, since there was no money awarded, the verdict curve always equals zero and is therefore not plotted. Of interest in this figure is that the defense offer no longer follows the expected value curve and falls far

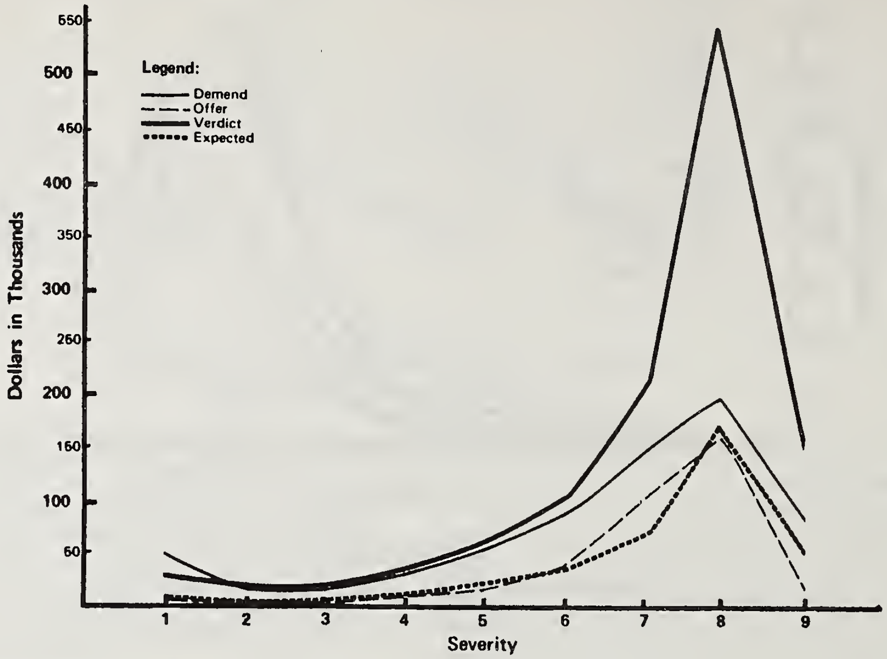


FIGURE 28
PLAINTIFF VERDICTS AGAINST PHYSICIANS

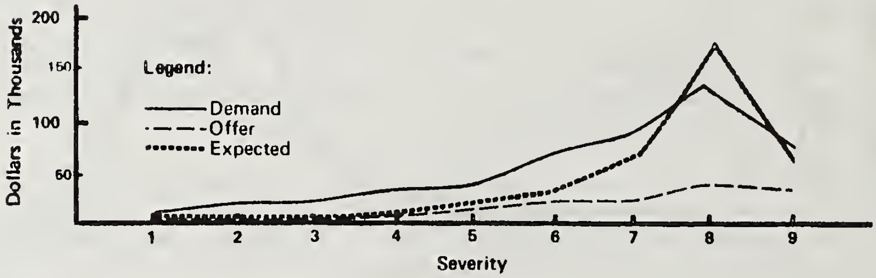


FIGURE 29
DEFENSE VERDICTS FOR PHYSICIANS

below it for higher severity cases. Also in contrast to the previous figure, while the plaintiff demand curve exceeds the expected value for lower severity cases, it does not exceed it as much as in those instances where the jury found for the plaintiff; it falls below the expected value for very high severity cases.

The figure suggests that attorneys for the plaintiff and defense are well able to weigh their actual probability of winning or losing a case in contrast to the theoretical probability of doing so. Based on the analysis, this tendency can be attributed to attorneys both for the plaintiff and the defense.

Conclusions

The preceding analysis shows that in those cases which are actually tried, there is a significant difference between the plaintiff's final demand and the defendant's offer. This difference, which represents the reason why the case is tried, closely follows the expected value as a function of case severity, and is apparently dominated by the attorney's view of whether he is likely to prevail at trial. In the analysis, rational behavior by both plaintiff and defense attorneys is shown. In the cases where the plaintiff prevailed, defense attorneys seemed to rely heavily on historical odds; in cases which were won by the defense, there appears a greater propensity to try the case than to settle, as is reflected by the far lower offers. By contrast, plaintiffs seem far more attracted to the potential verdict available, should they prevail in the case, for all but the very high severity and high potential verdict cases.

Further research in comparing this type of analysis of medical malpractice decisions with cases involving other personal injury would indicate whether the settlement practices of plaintiff and defense attorneys in the medical malpractice trial arena differ from those arising from other injury-producing circumstances.

The focus of this inquiry and its relevance to alternatives to litigation is significant—attorneys for both the plaintiff and defendant have an excellent view of their cases' economic worth and probability of prevailing. This suggests that if an alternative to litigation is to function effectively, it must do so based on the assumption that attorneys are very much aware of the merits and economic value of the cases they try.

As new forms of dispute resolution evolve in the medical malpractice setting, a comparison of decisions in those cases where monetary damages are recommended (as in the New Hampshire statutory plan) and where the resolution system is dispositive of the claim (as in arbitration) will determine whether amounts awarded by expert fact-finders differ significantly from those rendered by juries. Such an inquiry in future research might do much to assure the communities affected—physicians, attorneys, insurance, and public—that the new forms of dispute resolution pass the savings of their more economic operation where they rightfully belong, to the consumer of medical care. Finally, such research would do much to encourage the widespread acceptance and marketing of alternatives to litigation, if it could authoritatively and quantitatively be shown that the present balance of interests inherent in the tort litigation system is not materially altered, but only that the process is faster, less expensive, and private.

D. ACCEPTABILITY OF SCREENING PANELS TO VARIOUS PARTIES

The final dimension from which ultimately will evolve the widespread use of alternatives to litigation is the acceptability of those procedures, not only by the plaintiffs, but by the medical, legal, and insurance participants in medical malpractice disputes. This section brings together and analyzes quantitative and subjective information about acceptability of alternatives to litigation.

Physician Screening Panels

The widespread use of physician screening panels in association with the liability insurance carrier is indicative of the acceptability of this procedure to physicians. However, it has led to counter-movements by the legal profession. For example, the motivation behind establishment of the New Hampshire statutory procedure was, in large part, brought about by the difficulty of the physician screening panel coupled with the almost complete inability to obtain expert testimony from New Hampshire physicians.[27]

The influence on medical malpractice litigation by the new statute in this jurisdiction, which has been so heavily influenced by physicians in the past, is of interest. The attorney for the New Hampshire physician panel indicated that physicians vote to defend about 90% of the cases brought before their panel.[28] It has also been reported that plaintiffs have prevailed in only two medical malpractice cases in New Hampshire in the course of the past 40 years; one verdict was nullified by the Supreme Court of New Hampshire, and the other entered an award of only $1,000.[29]

Medical-Legal Screening Panels

An attitude survey was conducted in 1970 by the Arizona Medical Society to assess the attitudes toward malpractice and the malpractice insurer. The study was focused on the interest of society members in establishing their own program of liability insurance. Questionnaires were sent to the 1600 physician members of the society. Approximately 900 responded. The responses were analyzed by Patzman-Allen-Lamb and Associates, a Tucson, Arizona, insurance consulting and brokerage firm, and the results made available to this study by the Commission.

Upon an examination of the results, it became apparent that further analysis would be interesting in order to focus upon the attitudes of the physicians toward the screening panel in Pima County and to compare the responses between Maricopa County (which did not have an active panel at the time of the survey) and Pima County (which did). The following results are extracted from the Arizona Medical Society study, augmented by further analysis of 653 questionnaires which were complete in the area of interest, that of the attitudes toward the panel.

Response rates were extremely uniform, as shown in Table 15.

Table 16 shows the distribution of prior malpractice experiences of respondents.

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[27] Letter from David L. Nixon to Bird Associates, June 5, 1972. Senator Nixon was the sponsor of the New Hampshire Professional Malpractice Statute. During the legislative debates and compromises leading to enactment of the bill, its provisions were considerably watered down. Its original version provided for a binding decision by the panel and, as a backup position, that panel verdicts be read to the jury in any subsequent action at law. The tradeoffs during legislative debate and enactment, in giving up these provisions, were to render the locality rule inapplicable and make expert witnesses unnecessary during presentation to the panel. (New Hampshire Revised Statutes, Annotated, sections 519-A:7 and 519-A:6) The provision to make the decision of the statutory panel known to the jury in the event of a subsequent action at law was specifically proscribed upon enactment of the statute. (New Hampshire Revised Statutes, Annotated, section 519-A:8)

[28] If this off-hand report is accurate, the New Hampshire physician screening panel has a decision ratio far below that of the Medical-Chirurgical Faculty of Maryland physician panel—0.10 to 0.14.

[29] See Soden, "The New Hampshire Plan," 20 *Federation of Insurance Council Quarterly* 13 (Winter 1969-70).

TABLE 15
ARIZONA PHYSICIAN ATTITUDE SURVEY—RESPONSES BY LOCALE

Respondent's Location	Percent of Those Questioned	
	All Respondents	Arizona Physicians
Maricopa County (Phoenix Area)	62%	62%
Pima County (Tucson Area)	28%	24%
Rest of State	10%	14%

TABLE 16
ARIZONA PHYSICIAN ATTITUDE SURVEY—RESPONSES BY PREVIOUS MALPRACTICE EXPERIENCE

Malpractice Experience	Respondents	
	Number	Percent
No medical malpractice incidents or suits	143	22%
Incidents but no suits	143	22%
Suits:	86	13%
Appeared before screening panel	11	2%
Did not appear before panel:	75	11%
Pima County	11	2%
Other	64	9%

This distribution shows that of the 13% of the respondents who had been sued for medical malpractice, 2% had appeared before the Pima County screening panel; of the 11% who did not appear before the panel, only 2% were from Pima County. That is, of the Pima County physicians who had been sued, as many went before the panel as did not. It was these parallel groups of 22 physician questionnaires which were of particular interest, since they represent the attitudes of physicians who had been sued and who had the medical-legal screening panel available to them. Their responses to four questions of interest are analyzed in Table 17 in comparison to responses from a sampling of the three other groups.

The response to the first question (whether the panel is effective) is extremely positive, since the physicians more competent to answer—those with suits—answered "yes" a greater percentage of the time than the other population samples. Likewise, this group was highly in favor of mandatory submission to the screening panel and would be satisfied with peer review. The lowest "yes" response to the question was from those physicians who had been defendants in court, indicating that the experience of a suit may not be as negative as felt by those not having this experience, and perhaps a restatement of the right to a day in court. The last question was the most negatively answered, although the parenthetical expression "to uphold your professional reputation" would tend to induce negative responses. The response does indicate a reticence, although not in the majority, to allow an insurance company to settle based upon the screening panel decision.

One question for which the response seems dubious was: "Do you believe your County Medical Society has an adequate Medical/Legal Review Panel for screening plaintiffs in suits?" Although the question is perhaps ambiguously framed, the response of Pima County respondents who had not had a claim was split (50% "yes"). However, of those who did have claims, 82% felt the panel was adequate. Curiously, 25% of those responding in Maricopa County answered that their panel was adequate, when in fact none is known to have existed.

The attitude toward the legal representation reviewed by defendants appearing before the screening panel which reflects upon the attorney's attitude toward the panel was revealed by several questions. Of those involved as a defendant in a malpractice court proceeding, 85% felt they were properly defended. The comparable figure for the screening panel is that 87% felt they were properly defended.

Court-Sponsored Screening Panels

The New Jersey Panel

To derive an inference about the acceptability of court-sponsored screening panels from the perspective of attorneys, data from the New Jersey screening panel records were analyzed. These data show that 150 law firms were utilized by the plaintiffs in 177 randomly drawn cases. Except for one firm having five cases and another having seven cases, the data show a nearly one-to-one correspondence between the number of lawyers and the number of cases. There appears to be no "choice" firms to which claimants take cases. The data indicate only those cases involving the New Jersey screening panel which, based upon the data base of the 1970 insurance questionnaire results, represents about three percent of the malpractice cases in New Jersey. Table 18 provides a frequency distribution of the 177 cases for which data were available (from court year 1965 through court year 1970).

The seven cases taken by the single law firm showed that four cases were bunched in a span of several months, indicating a nonuniform rate.

The tabulated data is compared to that expected on the assumption that the selection of law firms is random, and thus that certain firms do not get most of the plaintiffs' malpractice cases. If the number of law firms which could accept malpractice cases is assumed to be large, say 700, the expected values found on the Poisson distribution for random selection are compared with the observed values in Table 19.

TABLE 17
ATTITUDES OF ARIZONA PHYSICIANS

Question	Total Yes* Response	Respondent Segment Answering "Yes"					
		Suits			Incidents (No Suits)	No Suits or Incidents	Had Been in Court as Defendant
		Pima County		Other			
		Used Panel	Did Not Use Panel				
Do you believe that such a joint medical-legal screening panel (especially if it had some element of compulsory or ethical submission) would effectively eliminate many of the suits which are unfounded but which cause large defense costs and subsequently drive up rates?	94%	100% (10/10)	91% (10/11)	90% (9/10)	78% (7/9)	86% (16/22)	86% (6/7)
Would you like to see *mandatory* submission to a joint medical-legal panel before a plaintiff's case could be taken to court?	98%	86% (6/7)	90% (9/10)	90% (9/10)	90% (9/10)	96% (21/22)	50% (3/6)
Would you be satisfied with a "peer review" and accept its findings?	92%	90% (9/10)	80% (8/10)	100% (10/10)	90% (9/10)	91% (21/23)	71% (5/7)
Would you waive your right to insist upon going to court (to uphold your professional reputation) versus allowing the insurance carrier the option to settle or fight, if there were a finding of a possibility of malpractice by a joint medical-legal screening panel?	71%	67% (6/9)	75% (6/8)	60% (6/10)	67% (6/9)	71% (15/21)	67% (4/6)

* As reported in the analysis of the survey (letter to Board of Directors, Arizona Medical Association, May 16, 1970). The floating base is due to the response of "don't know", which was not included.

TABLE 18
FREQUENCY DISTRIBUTION OF LAW FIRMS AND CASES HANDLED

Cases Per Firm	Number of Law Firms	Number of Cases
1	131	131
2	16	32
3	1	3
4	0	0
5	1	5
6	0	0
7	1	7
	150	177

TABLE 19
OBSERVED VERSUS EXPECTED CASES PER LAW FIRM

Cases Per Firm	Observed Screening Panel Data	Expected for Random Selection
1	131	138
2	16	17
3	1	1
>4	2	0

The expected distribution, except for the two extreme cases, agrees with the observed data and thus shows no tendency for the plaintiffs' cases to be concentrated in a few law firms.

It should be noted that this conclusion holds for only those cases heard before the panel; and while thus indicative of the type of firms or firm practices which use the screening panel, it probably does not apply to the selection of plaintiff's law firms involved in the great majority of New Jersey malpractice cases.

During the "Legal Systems Study", a selected survey of lawyers known to be devoting a substantial portion of their professional energies to the field of medical malpractice cases were interviewed in New Jersey. Almost overwhelmingly, these specialty practitioners indicated that they did not make use of the court-sponsored screening panel. The reason most frequently advanced was that the requirement that the claimant drop the lawsuit in the event of an adverse finding was far too harsh to accept, and that the plaintiff had a greater chance of prevailing in a trial by jury.[30]

The records of the New Jersey panel also contain information showing the utilization of the panel by claimants and defendants. To assess this question, data over several years of operation of the panel were studied, and previous studies of the New Jersey panel were also analyzed. In a recent study, it was determined that in 1969 approximately 17% of the medical malpractice cases in the Superior Courts were filed with the panel.[31] An examination of the study indicates that the number of cases disposed of was only about 6%; the balance were withdrawn from the panel before the hearing stage and therefore did not reduce the total court docket load. This information is plotted in Figure 30.

Of all claims filed with the panel, the portion which reached its hearing phase ranges from 38% to 57%. This small percentage of cases reaching the hearing stage was not found with any of the other panels studied and perhaps indicates a level of displeasure with the panel.

During the extraction of data from the files for this study, the routine practice of successive postponements was noted. In addition, in conversations with individuals close to the administration of the panel, the existence of the option for a binding decision was frequently mentioned as a factor tending to discourage use. The percentage of withdrawals from the panel and the reasons given for them are shown in Table 20 for the five years for which complete data were available.

The table reveals an apparent trend of an increasing percentage of withdrawals by the plaintiff. The percent of defendant consent refusals, however, appears to be decreasing. This increase in plaintiff withdrawals, coupled with the previously indicated decrease in the number of claims filed with the panel, suggests the plaintiff's movement away from use of the panel but a growing acceptance of it by defendants.

This trend toward reduced use of the New Jersey screening panel is even more striking when the number of claims filed with the panel is compared to the number of claims reported by the New Jersey Medical Society. This comparison is shown in Table 21.

This inference of the decrease in percent filed could be invalid if a larger percentage of claims is being settled prior to filing. However, the increase of such a practice is unlikely to be as marked as the decrease shown by these figures. In addition, but not shown in the table, the decrease in number of claims filed in 1972 (as of December 1) is only 18 as compared to the total of 34 in 1971, further indicating a decreased usage of the panel.

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[30] Supra, pp. 87 ff.

[31] Memorandum from W. M. Bielanowski to W. L. Bambrick, Assistant Administrative Director of the Courts, "Medical Malpractice Complaints Filed in 1969," December 4, 1970.

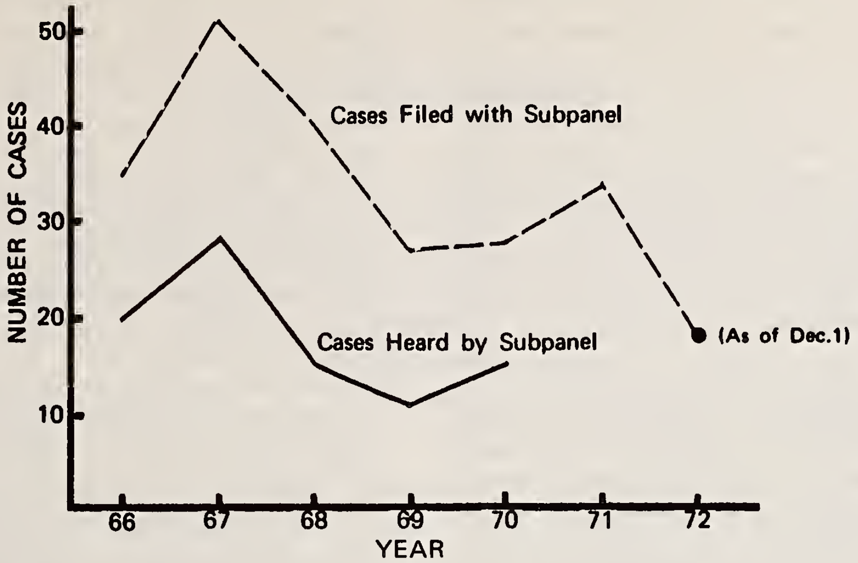

FIGURE 30.
CASES FILED AND CASES HEARD—NEW
JERSEY COURT-SPONSORED SCREENING PANEL

TABLE 20.
DISPOSITION OF CLAIMS FILED—NEW JERSEY
COURT-SPONSORED SCREENING PANEL

Claims	1966	1967	1968	1969	1970
Number Filed (100%)	35	51	40	27	28
Settled Prior to Panel	0%	3%	4%	11%	0%
Withdrawn by Plaintiff	17%	19%	25%	22%	32%
Consent Refused by Defendant	26%	23%	33%	26%	14%
Heard by Panel	57%	55%	38%	41%	54%

TABLE 21.
NEW JERSEY CLAIMS REPORTED
VERSUS SCREENING PANEL FILINGS

Claims	1969	1970	1971
Number Reported	212	352	593
Number Filed With Panel	27 (13%)	28 (8%)	34 (6%)

Administrators of the New Jersey plan believe that defendants, upon the advice of their insurers, will not consent to the panel hearing unless the claimant agrees to accept the panel's decision as binding. The percent of the claimants who agree to accept the panel decision is shown, by year, in Figure 31, which also gives the percent of claims for which consent by the defendant was refused. While appearing to be fairly constant, the above postulated statement is verified to a small degree. That is, as the percentage of claimants who agree to accept the decision increases, the consent refusals decrease. This sensitivity, although slight, is verified over several slope changes.

In summary, the usage of the New Jersey panel, while never high, is apparently decreasing. This is indicated by a reduction in claims filed and an increase in claims withdrawn by the claimants. The findings of the New Jersey panel are approximately the same as for claims decided by actions at law. There does appear to be a slight sensitivity between the percent of claimants who agree to accept the panel's findings and the percent of defendant consents refused.

New York Mediation Program

A questionnaire was sent by the sponsors of the New York panel to all panelists and attorneys for litigants who appeared on or before the panel. Table 22 summarizes the number of questionnaires sent and analyzes responses.

The responses indicate a high level of approval by those who responded. About one-half of the lawyers felt the information presented prior to the session was inadequate, while 73% of the doctors felt the information was adequate. This is merely a reflection of the procedure where the physician researches the case prior to the panel hearing while the lawyer does not. The influence of the panelists was greatest on the lawyers and received a split vote among the doctors. Neither doctor nor lawyer panelists felt strongly that counsel was adequately prepared, although their preparations were of some assistance.

Of the litigants' attorneys questioned, 23 plaintiff attorneys and 8 defendant attorneys responded. These 31 attorneys represented clients in 78 cases heard. Their responses are summarized in Table 23.

Based upon this limited data, the reaction of the attorneys for the litigants appears highly favorable. They were opposed, however, to the suggestion that parties furnish the panel with written memoranda of position and facts. Defense attorneys were somewhat more negative than plaintiffs' attorneys, although to no statistically significant degree. This lack of enthusiasm of litigants' attorneys to prepare briefing material to the panel is an interesting contrast to the low marks which panelists gave attorneys for case preparation. If these views (the need for information versus the willingness to provide it) cannot be reconciled, the new panel so vigorously started may ultimately be viewed as only one more time-consuming hurdle to be overcome in a jurisdiction whose docket delay has already reached massive proportions.

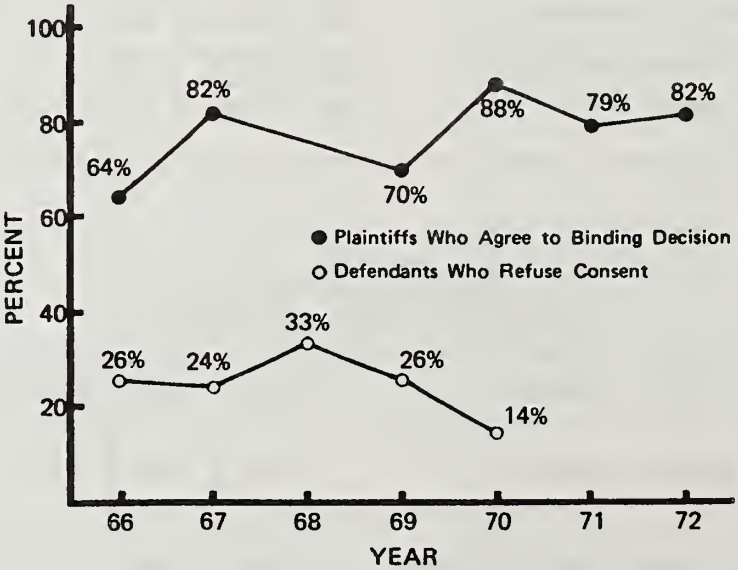

FIGURE 31.
LITIGANTS' DECISION ABOUT PLAN OPTIONS

TABLE 22.
NEW YORK MEDICATION PROGRAM ATTITUDE SURVEY–PANELISTS' RESPONSES

Question	Response	Doctors	Lawyers
General reaction to program ?	Favorable or Qualified Approval	100% (51/51)	97% (29/30)
Reaction to structure?	Favorable	92% (45/49)	96% (27/28)
Views re adequacy of info furnished prior to mediation?	Adequate	73% (37/51	52% (15/29)
Was respondent influenced by views of other panelists?	Yes	50% (25/50)	89% (25/28)
Were counsel adequately prepared?	Yes	49% (23/47)	39% (11/28)
Were counsel's preparations of assistance?	Yes	67% (32/48)	60% (15/25)

TABLE 23.
NEW YORK MEDIATION PROGRAM ATTITUDE SURVEY–LITIGANTS' ATTORNEYS RESPONSES

Question	Response	Plaintiff Attorneys	Defense Attorneys
General reaction to program?	Favorable or With Qualification	89% (16/18)	67% (4/6)
Reaction to panel structure?	Favorable or With Qualification	100% (23/23)	100% (7/7)
Reaction to suggestion that parties furnish panel with written memorandum of position and facts?	Favorable	48% (11/23)	33% (2/6)

E. IMPACT OF ALTERNATIVES TO LITIGATION ON DOCKET LOADS

This section analyzes the impact which alternatives to litigation have on the workload of the courts. Those plans which operate as adjuncts to the judicial process are investigated to determine the extent to which they perform their stated mission; and case disposition and processing of arbitration is compared to processing by actions at law.

Physician Screening Panels

No precise quantitative estimate can be made of the extent to which physician screening panels reduce the workload of the courts, since only fragmentary information exists about these procedures. However, the extent to which the Med-Chi Faculty of Maryland physician screening panel has heard and decided cases does give a modest glimpse of what these panels perhaps accomplish. In an extensive study which analyzed over a decade's experience from 1960 to 1970 of professional liability incidents in Maryland, a total of 381 completed claim files were analyzed.[32]

Unfortunately, this comprehensive study (which focused on broader objectives) chose definitons of a claim incompatible with this study. Two definitions of a malpractice claim used in the Med-Chi study were an "incident" (a claim against a physician where no legal counsel was obtained) and a "suit" (where a lawyer had entered the case or suit was actually filed in court). Med-Chi panels were provided for 90 claims, of which 10 were based on "incidents" and 80 on "suits". The recommendations of the Med-Chi panel, however, were provided for only 36 of the 90 panels held, since the major inquiry of the study was not aimed at panel effectiveness.

Subsequent analysis of more complete data with 49 decisions available indicates that 42 panel decisions were rendered as "defensible" and 7 as "nondefensible", for a decision ratio of 0.14 for the cases reported. Four nondefensible decisions were given for incidents only. The analysis of the disposition of the suits based on the screening panel disposition shows that 19 of the total number of claims held "defensible" were still pending. Two were settled, four withdrawn by the plaintiff, while of those that went to trail, two received jury verdicts and one summary judgment, all for the defense. None of the "nondefensible" claims was pending, although at least five had proceeded to an action at law, with four settled and one verdict for the plaintiff, indicating that the panel decision was never reversed. The maximum extent to which this physician screening panel would reduce the volume of medical malpractice litigation would be its decision ratio, or 14% of the actions reviewed by it.

The Med-Chi Faculty did not hold panels on that large a percentage of total actions, for, as reported earlier, panels were provided for about 90 claims on 123 "incidents" and 258 "suits" (or 381 claims)—about 23.6% of the potential malpractice claims in Maryland over the period. Assuming the same 0.14 decision ratio and further that all cases which the panel determined to be nondefensible were settled, the maximum reduction at the panel's current workload would be 0.24 times 0.14, or about 3.4% of the total volume of potential medical malpractice litigation.

Medical-Legal Screening Panels

Cases involving 110 defendants were examined in Pima County, Arizona, which included cases initiated by actions at law and cases initiated with the medical-legal screening panel. Approximately 52.7% of the cases were initially pursued by action at law, with 47.3% first going to the screening panel.[33] The complete disposition of all 110 defendants is shown in Figure 32. This figure is a flow oriented diagram in which all cases are shown, starting at the left, and the flow through the various stages, whether action at law or screening panel, is shown. The impact of the alternatives to litigation upon the action at law volume is indicated by the shaded area.

The figure indicates that of the 47.3% (claims initiated with the screening panel), the panel rendered decisions in about two-thirds of the cases, with no decisions in about one-third. Of the cases where decisions were rendered, 14.5% of the total number of claims in Pima County were terminated at that juncture. In those instances where the panel did not render a decision, 10.0% of the total claims were terminated at the screening panel level. Of the two-thirds of the claims coming before it which the panel heard, slightly more than half (or 17.3% of the total) proceeded to the action at law. In the one-third of the opportunities for panel hearings for which no hearings were held, 5.5% of the cases resulted in an action at law. The balance of the figure shows the resulting activities and events as a percentage of total defendants. Only 14.5% of the total number of cases entering the court actually were disposed of by it.

From the foregoing analysis, it is noted that the reduction in the volume of litigation in Pima County which could be attributed to the screening panel is 24.5%. Of further interest is that of the remaining cases, 4.5% of the total were disposed of by the court by means of directed verdict or summary judgment.

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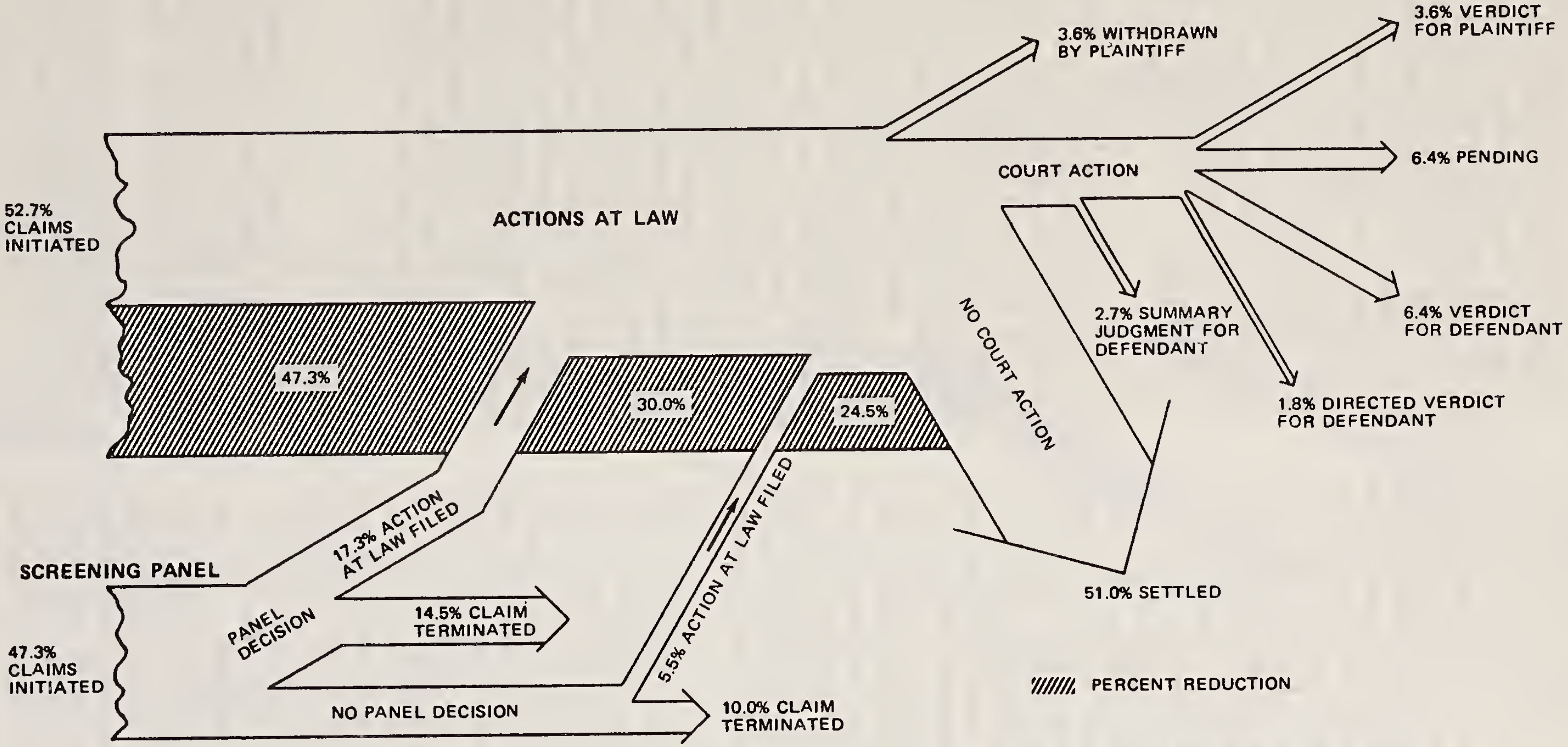
[32] See "A Survey of Professional Liability Incidence in Maryland," *Infra,* pp. 623 ff.

[33] This significant percentage of cases initially bypassing the screening panel should not be misinterpreted as an indication of its ineffectiveness. Of the cases proceeding directly to actions at law, 82% bepassed the panel because of jurisdictional limitations, viz., physician an indispensable party joined with an institutional or corporate defendant, or not a member of the medical society (osteopath). Of the cases which could have been resolved by the Pima County panel under its current rules, 91% were brought before it first.


52.7%
CLAIMS
INITIATED
ACTIONS AT LAW
47.3%
30.0%
24.5%
3.6% WITHDRAWN
BY PLAINTIFF
COURT ACTION
3.6% VERDICT
FOR PLAINTIFF
6.4% PENDING
6.4% VERDICT
FOR DEFENDANT
2.7% SUMMARY
JUDGMENT FOR
DEFENDANT
1.8% DIRECTED VERDICT
FOR DEFENDANT
NO COURT ACTION
51.0% SETTLED
SCREENING PANEL
47.3%
CLAIMS
INITIATED
PANEL
DECISION
17.3% ACTION
AT LAW FILED
14.5% CLAIM
TERMINATED
NO PANEL DECISION
5.5% ACTION AT LAW FILED
10.0% CLAIM
TERMINATED
▨ PERCENT REDUCTION

SOURCE: 110 Case-Defendants, Pima County, Arizona

FIGURE 32.
QUANTITATIVE IMPACT ON LITIGATION OF MEDICAL-LEGAL SCREENING PANEL

This 24.5% reduction in court medical malpractice litigation attributed to the Pima County screening panel can usefully be contrasted with the disposition of 123 defendants in actions at law in Maricopa County. The disposition of defendants as a percentage of the total is shown in Figure 33. No cases were disposed of by a screening panel, since Maricopa County did not have one during the period studied. Aside from cases withdrawn or abandoned and cases settled, there is substantial contrast between the two jurisdictions. As noted, only 14.5% of the cases were disposed of by the court in Pima County; in Maricopa County, 26.8% of the cases were disposed of by the court. Of these, 13.0% of the total were by summary judgment, with the remaining 13.8% reaching the trial stage. And the court disposed of 4.1% of the cases tried through directed verdict for the defendant.

The differing behavior of these two jurisdictions can be contrasted to show the way claims are disposed of in a jurisdiction with a screening panel and a jurisdiction without one. Table 24 indicates these differences in cases handled in Maricopa County and Pima County, showing the percentages of total cases as they differ between the two jurisdictions. Noted in the table is that Maricopa County had greater proportions of cases withdrawn from actions at law, summary judgments for the defendant, and directed verdicts for the defendant, as well as a higher proportion of cases settled. Adjusting the differing percentages of total cases (to remove pending cases in Pima County and the 24.5% cases settled by the Pima County medical-legal screening panel) yields a net total difference of less than 1% in the overall percentage distribution of cases by these two neighboring jurisdictions.

In summary, this closeness of the adjusted overall percentage distributions is indicative of the way the presence of a screening panel affects the behavior of case disposition. It is concluded that the medical-legal screening panel in Pima County is performing its stated function of screening out meritorious cases which are presumably settled, but more important that it is discouraging frivolous claims. Although the very choice of the terminology "frivolous claim" is argumentative; the greater withdrawal rate, the far greater summary judgment rate, and the slightly higher percentage of directed verdicts and settlements in Maricopa County could be considered as cases having questionable legal merit. Even though this conclusion is not as strong for the 8.4% difference in cases settled as it is for those withdrawn or those decided in favor of the defendant by the court, even this difference is not large.

Finally, the examination of the distribution of the total percentages of case distributions in these two jurisdictions does not support the frequent criticism of alternatives to litigation—that they increase the number of frivolous claims. It may well be that the number of claims between the two jurisdictions, as a percentage of physicians or hospitals, may be higher or lower in one or the other. What is important, however, is that of the total volume of medical malpractice litigation, about one-fourth does not reach the formal stage of an action at law in a jurisdiction where there is a medical-legal screening panel.

Court-Sponsored Screening Panels

The objective of court-sponsored screening panels is principally to remove cases from the trial docket rather than to discourage the filing of actions at law. Even though the rules of the court-sponsored panels provide for hearings prior to the filing of an action at law, this objective has not been tried in New York and is frequently frustrated in New Jersey by dilatory tactics of the defense.

Figure 34 shows the disposition by the New Jersey screening panel of 159 cases examined for the year 1969. Approximately 17% of the cases were filed with the screening panel, and of these, only 6% were disposed of as a consequence of actions of the panel. The remaining 11% went to the trial docket. It is concluded that the effect of the New Jersey court-sponsored screening panel is only a minor reduction of the total malpractice litigation docket load.

The New York panel has not operated long enough to determine its continuous effectiveness in reducing docket load, although the early experiment noted results similar to those of the Pima County panel. After the New York mediation panel has operated as a continuous adjunct to the judicial machinery, its effectiveness will provide an interesting area for future research. For this to be done, however, better records must be kept. For example, the New York screening panel did not maintain records of the ultimate disposition of cases heard before it. Settlement negotiations following the mediation panel's deliberations may have taken many weeks. One noted weakness in the panel in its evaluation report was that parties frequently appeared before the panel without the authority to agree to settlement. One proposed rule change is to require, prior to the hearing, stipulations that the attorneys representing both parties have authority to settle the claim at the mediation hearing. Traceability of cases heard by the New York panel proved complex and beyond the resources of this study. It is suggested that all such future endeavors to establish claims disposition or resolution mechanisms establish for their own evaluation sufficient accurate data to gauge operating effectiveness and, particularly, to ensure traceability of cases so that the impact on the judicial system which the procedure seeks to accommodate can be accurately measured.

Arbitration

Although arbitration is a complete substitute for an action at law rather than an adjunct to it, the case disposition behavior of the Ross-Loos Medical Group is included in this portion of the report for comparison of its case disposition percentages with those previously discussed.

Figure 35 displays the reported disposition of 177 medical malpractice incidents on file at the Ross-Loos Medical Group.[34] Not all of the 177 incidents, in the

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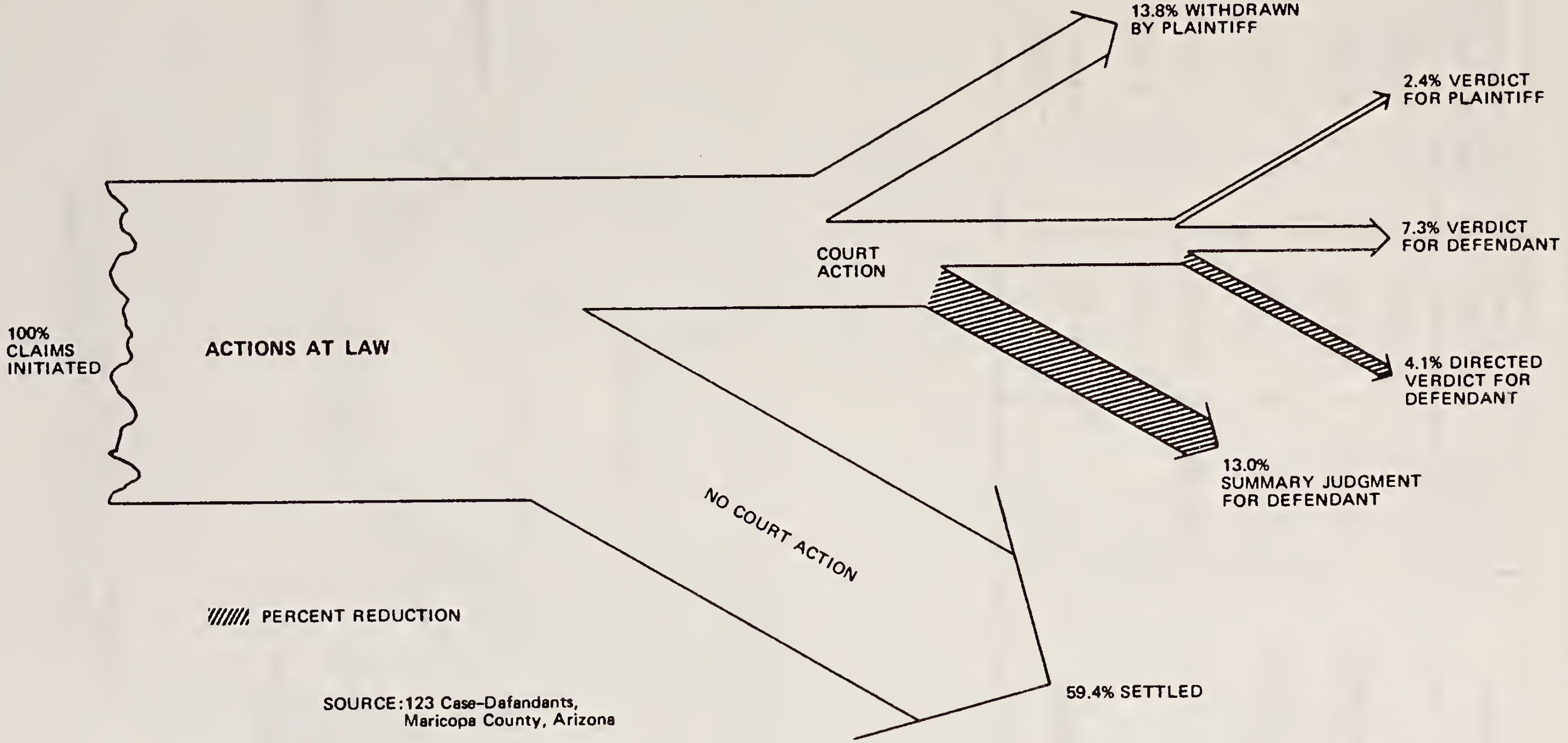
[34] See "The Experience of Binding Arbitration in the Ross-Loos Medical Group" *Infra*, pp. 424 ff.

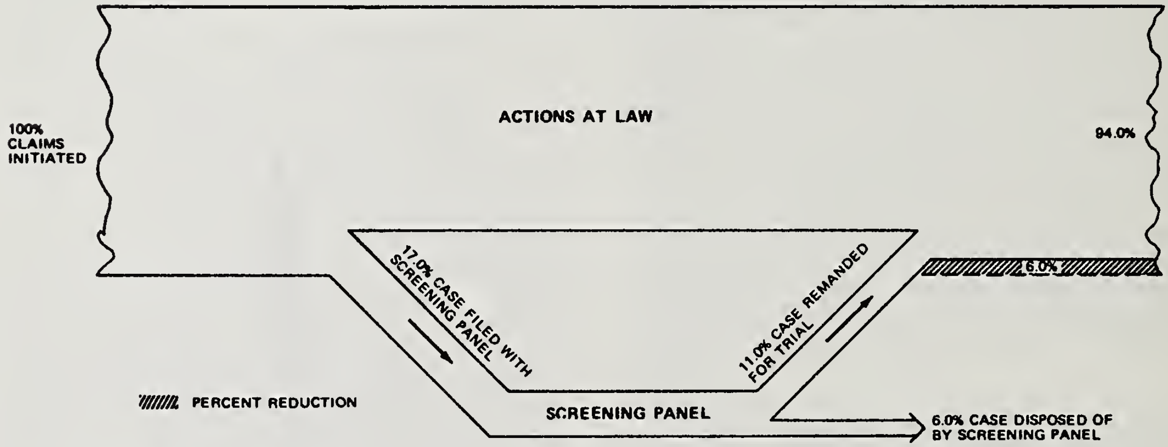

13.8% WITHDRAWN
BY PLAINTIFF
2.4% VERDICT
FOR PLAINTIFF
7.3% VERDICT
FOR DEFENDANT
COURT
ACTION
4.1% DIRECTED
VERDICT FOR
DEFENDANT
100%
CLAIMS
INITIATED
ACTIONS AT LAW
13.0%
SUMMARY JUDGMENT
FOR DEFENDANT
NO COURT ACTION
▨ PERCENT REDUCTION
59.4% SETTLED

SOURCE: 123 Case-Dafandants,
Maricopa County, Arizona

FIGURE 33.
QUANTITATIVE IMPACT ON LITIGATION OF COURT DISPOSITION IN ACTIONS AT LAW

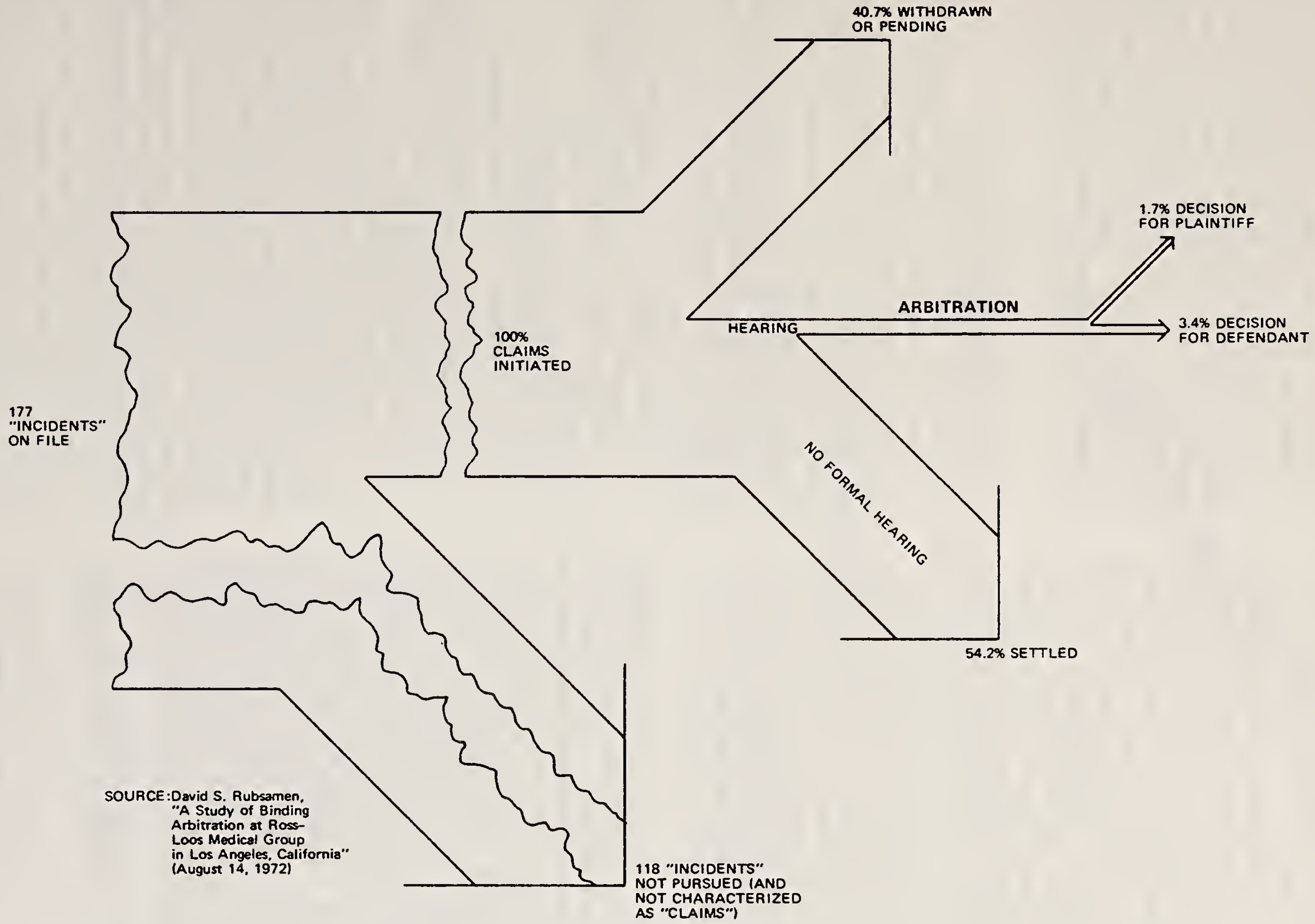
TABLE 24.
DISPOSITION OF CASES BY TWO COURT SYSTEMS

Disposition	Maricopa County	Pima County	Difference Maricopa – Pima
Withdrawn	13.8%	3.6%	10.2%
Summary Judgment for Defendant	13.0%	2.7%	10.3%
Directed Verdicts for Defendant	4.1%	1.8%	2.3%
Settled	59.4%	51.0%	8.4%
Pending	0	6.4%	(6.4%)
Settled by Screening Panel	0	24.5%	(24.5%)
			0.3%


100% CLAIMS INITIATED
ACTIONS AT LAW
94.0%
6.0%
17.0% CASE FILED WITH SCREENING PANEL
11.0% CASE REMANDED FOR TRIAL
SCREENING PANEL
6.0% CASE DISPOSED OF BY SCREENING PANEL
▨ PERCENT REDUCTION

SOURCE: 159 Cases New Jersey Superior Court

FIGURE 34.
QUANTITATIVE IMPACT ON LITIGATION OF
COURT-SPONSORED SCREENING PANEL


40.7% WITHDRAWN
OR PENDING
1.7% DECISION
FOR PLAINTIFF
ARBITRATION
HEARING
3.4% DECISION
FOR DEFENDANT
100%
CLAIMS
INITIATED
177
"INCIDENTS"
ON FILE
NO FORMAL HEARING
54.2% SETTLED
118 "INCIDENTS"
NOT PURSUED (AND
NOT CHARACTERIZED
AS "CLAIMS")

SOURCE: David S. Rubsamen, "A Study of Binding Arbitration at Ross-Loos Medical Group in Los Angeles, California" (August 14, 1972)

FIGURE 35.
QUANTITATIVE SUMMARY OF CLAIMS DISPOSITION IN "ARBITRATION"

opinion of the study, were worthy of characterization as "claims." Based on a judgment that only about one-third could be so characterized, approximately 59 claims were taken as the percentage basis for the disposition information shown in the figure.[35]

The figure notes available statistics about arbitration at Ross-Loos. The most remarkable feature of the plan's operation is that only 5.1% of the claims were actually disposed of by arbitral hearings. This figure is contrasted with the 13.8% of cases disposed of by trials in Maricopa County and a total of 26.8% disposed of by trials and summary judgment, and can also be compared to the 14.5% disposed of by trials and summary judgment in Pima County. It is concluded that the only arbitration plan which has produced enough information for even limited quantitative study disposes of its cases with one-fourth to one-third of the frequency of formal hearings by actions at law in jurisdictions with or without a medical-legal screening panel.

While this contrast of formal hearings in arbitration with the judicial process is of interest, it must be recognized that all of the claims settled, withdrawn, pending, or disposed of by formal hearings in the arbitration process at Ross-Loos reduced the court docket load by the total number of claims. The widespread use of arbitration in resolving medical malpractice disputes would have a far greater impact on the litigation caseload than any plan studied.

Conclusions

In summary, this brief analysis of the quantitative impact of alternatives to litigation on the court docket load indicates that the medical-legal screening panel has demonstrated a far greater reduction in formal actions at law than any plan studied. Judicially-sponsored settlement mechanisms had a disappointingly small reduction on the number of cases litigated. The full impact of physician screening panels cannot be judged with certainty, but their influence is apparently even smaller than that of the court-sponsored screening panels. Arbitration is as yet an unknown quantity with great potential. Finally, it is concluded that the ultimate resolution of claims is not materially altered by the presence of a medical-legal screening panel, for in the jurisdiction studied which did not have such a panel, the court showed a striking propensity to award summary judgments and directed verdicts.for the defendant. To the degree that the cost of reaching settlement at the summary judgment stage in an action at law is far less than the completed trial, the courts appear to protect adequately the interests of the litigants.

F. COSTS OF ALTERNATIVES TO LITIGATION VERSUS COSTS OF THE ACTION AT LAW

This section of the report presents a comparative cost assessment of resolving medical malpractice disputes by the alternative resolution methods with the action at law. In the analysis, cost estimates were prepared for the investigation phase, preparation phase, and hearing phase of each claims resolution method. These costs are divided between plaintiff, defendant, and other parties incurring costs, and estimated over three representative levels of case severity.

The nine-point severity scale (previously used in the analysis of other elements) was simplified for this cost analysis into three representative cases to examine cost sensitivity as a function of case complexity. Implicit in this methodology was the assumption that legal complexity is a function of injury severity. This correlation to one cost factor, the number of court days to verdict, is shown in Figure 36. The difference between plaintiff and defendant verdicts in terms of this correlation is not great.

The three bases used in the analysis were:

- Case A—severity levels 1, 2, and 3;
- Case B—the mid range of injury severity cases which combined severity levels 4 and 5; and
- Case C—severity ranges of levels 6, 7, and 8.

Severity level 9 (death) was not treated discretely due to the complexity of issues and due to the fact that award values tended to center in the mid-severity range (represented in this analysis by Case B).

Several additional simplifying assumptions were made to provide meaningful comparative analyses without undue complication. These assumptions were:

- Appellate actions were not included in the cost comparison. The cost estimates were based on the assumption that the forum hearing a claim, in fact, resolved it.
- Only one attorney represented the plaintiff, and one attorney represented the defendant.
- Only single-defendant cases were considered.
- Economic cost or lost-opportunity costs such as jurors' salary, panelists' time, plaintiff's and defendant's time, and working time lost by witnesses were estimated on an approximate scale.

The focal point of this analysis was to create comparative cost magnitudes rather than produce discrete quantitative estimates. Emphasis was first placed on task identifications and items that incurred costs in each method of resolving a medical malpractice dispute to ascertain that no significant aspect or procedure was omitted. Following adoption of the case cost elements, items representative of the task duration and cost per unit of duration for each alternative were estimated. Finally, quantitative estimates and cost factors were combined to produce the total cost of case processing by each alternative. The methodology for this analysis is shown in Appendix B.

Shown in Figure 37 are the estimated costs for both parties to a medical malpractice dispute for the three severity levels and five methods of resolution studied. However, more important than the information shown in Figure 37 which is, although comparative, not normalized to the action at law, is that information portrayed by Figure 38, which is the relationship of total

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[35] *Ibid.*

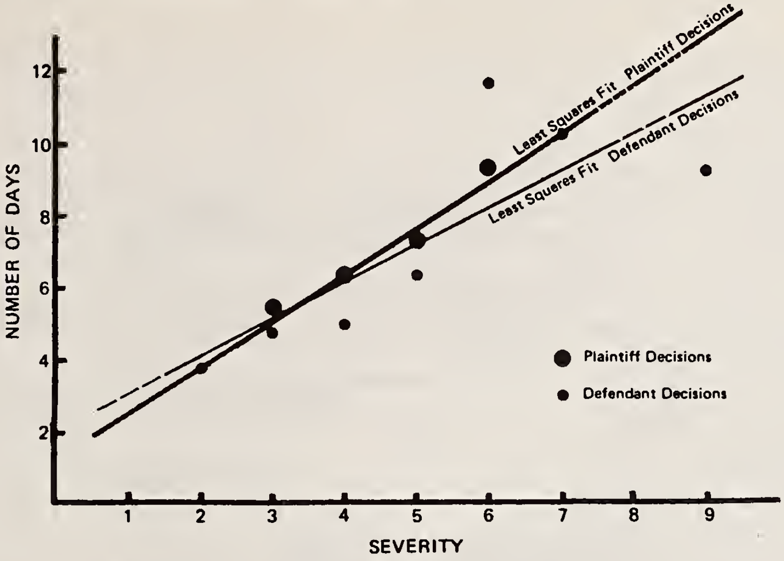

FIGURE 36.
TRIAL TIME VERSUS CASE SEVERITY

case costs of alternatives to an action at law versus severity level, normalized to the midrange case severity (case B) of an action at law. The figure estimates that to resolve a dispute by a physician screening panel is only about 20% of the cost of resolving a case by an action at law. Further, there is little cost sensitivity as a function of severity in this method of resolution.

By contrast, medical-legal screening panels were estimated to cost approximately 40-60% of the cost of resolving the mid-range severity cases by an action at law. In the case of the medical-legal screening panel, however, there was a greater cost sensitivity as the case became more complex.

Arbitration, as estimated, would require from about 55% to 85% of the cost of a mid-range action at law with a greater sensitivity to case severity than the physician screening panels or medical-legal screening panels.

Court-sponsored screening panels, by contrast, were almost as expensive as resolving a case by an action at law. This is because the majority of the court-sponsored screening panel's legal work to ready a case for decision on its merits had already been accomplished at the time the case reached the panel. In addition, the cost sensitivity for court-sponsored screening panels approached that of an action at law.

Finally, actions at law showed a high sensitivity to case severity or complexity, ranging from 70% to about 135% of the mid-range cost estimate.

G. ANALYSIS OF PROCEDURAL ATTRIBUTES OF ALTERNATIVES TO LITIGATION

Analysis of the Rules of Alternatives to Litigation

Introduction

This section of the report analyzes in detail the rules of procedure of the various forms of alternatives to litigation and compares them with procedures traditionally found in an action at law.

Although screening panels are merely an adjunct to the action at law and arbitration a contractual substitute for it, the way these devices operate can usefully be examined alongside procedural attributes evolved over many years for the resolution of controversies by actions at law.

Most of this analysis was taken from the published rules of the various alternative plans to litigation. However, during the course of the study, it was determined that many informal procedures not contained in the formal by-laws and rules were significant in the operation, success, or limitations of the plans. These informal factors were collected from interviews with those most directly involved with administration of the plans, and are included in this section to portray a complete picture of how the plans work.

Many of these plans contain a number of provisions which appear implicit in their formation and operation even

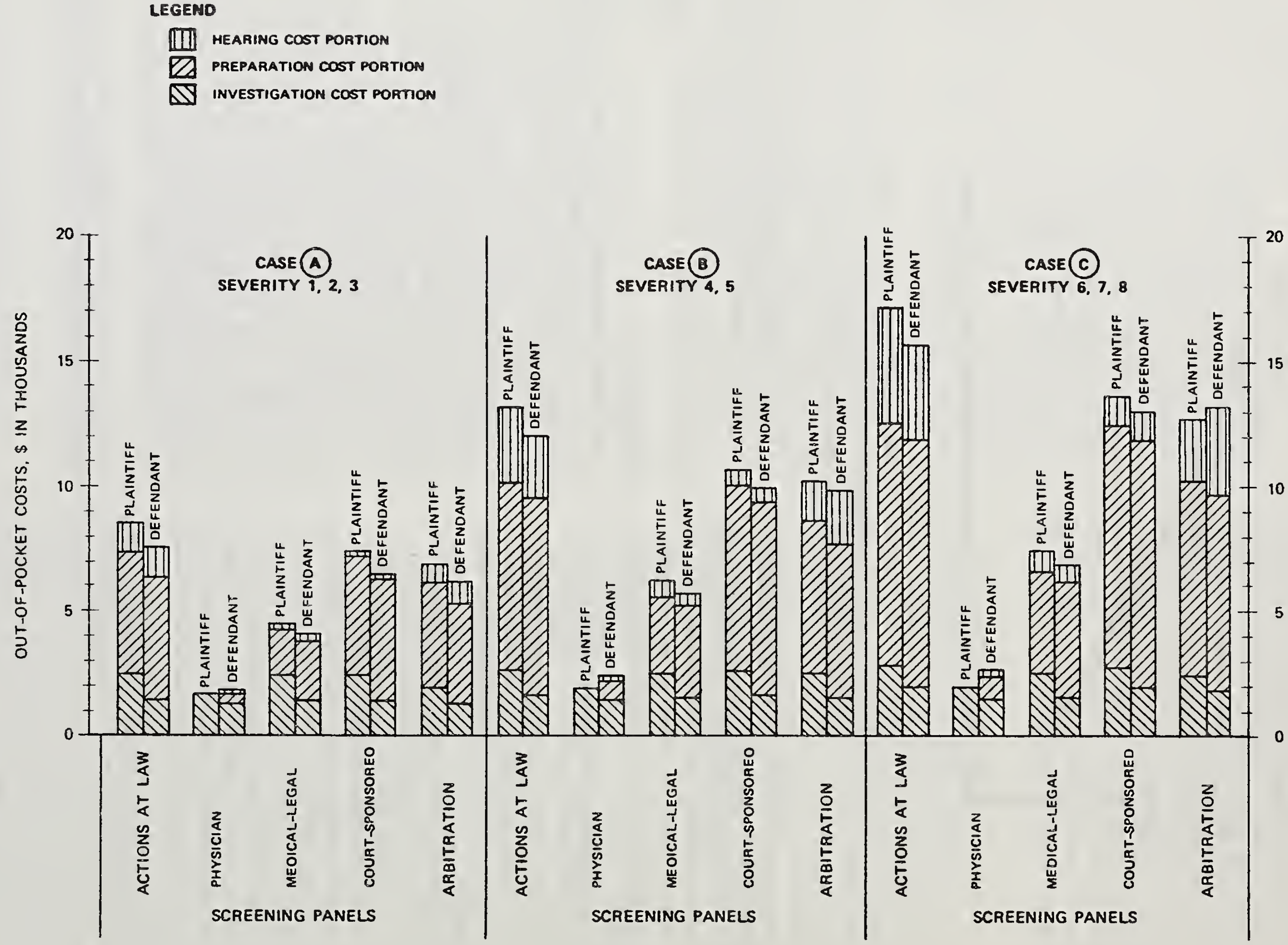

FIGURE 37.
COMPARATIVE COST FOR BOTH PARTIES BY ALTERNATIVE FOR THREE SEVERITY LEVELS

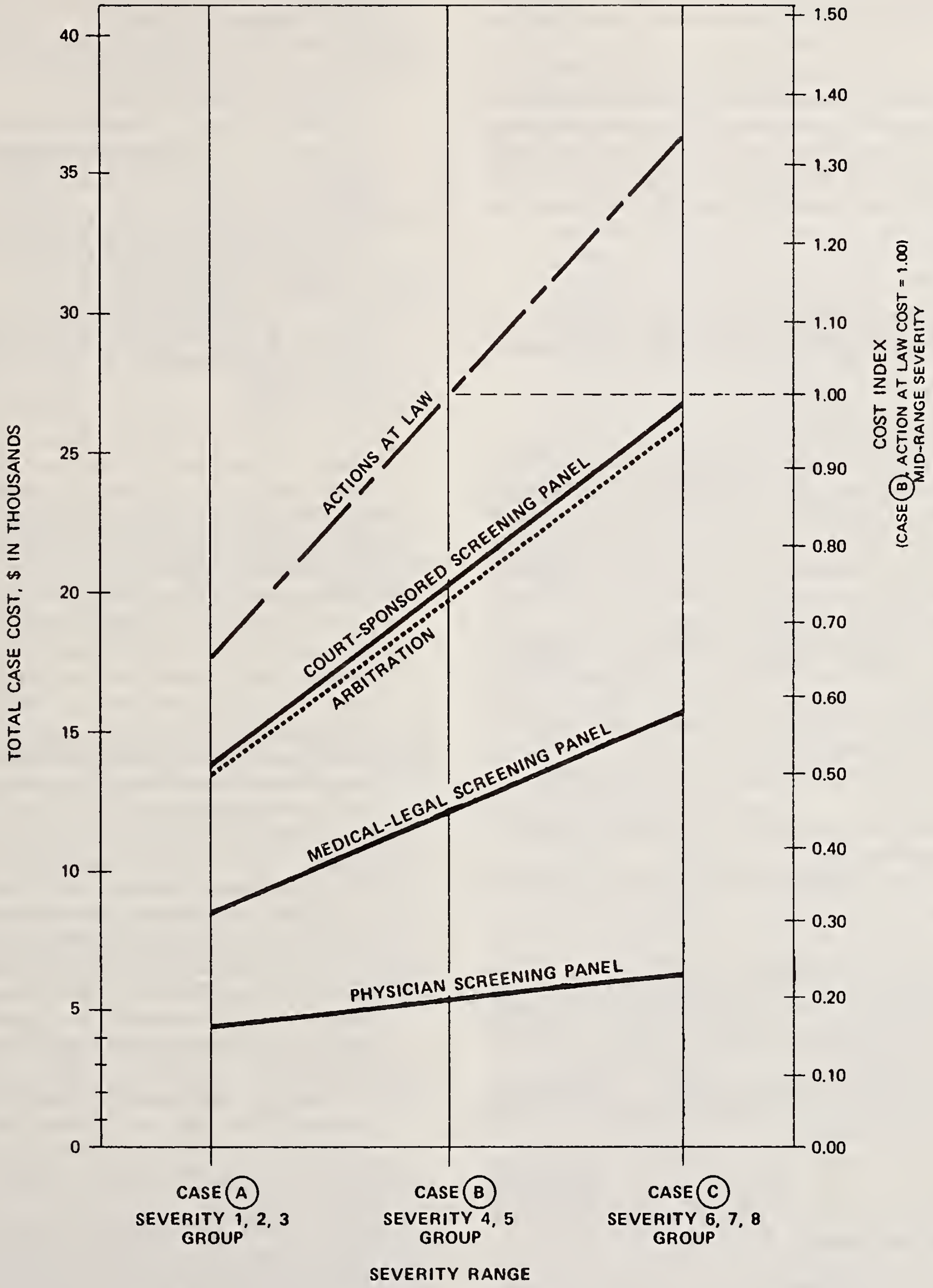

FIGURE 38.
RELATIONSHIP OF TOTAL CASE COST OF ALTERNATIVES TO ACTION AT LAW FOR A RANGE OF SEVERITY LEVELS

though they are neither stated in the rules nor volunteered by those administering them. These implicit goals and values of the plans, along with observations about them, are presented in the analysis which follows.

Finally, a thorough analysis of these rules of procedure and reported observations about how they are actually used required interpretive commentary. In general, the major issues associated with these subjective observations about the various facets of the plan are clearly identified and, where possible, the countervailing points of view are presented.

Scope of Review

The form, purpose, and essential characteristics of the alternative plans to litigation are discussed in the paragraphs which follow.

Physician Screening Panels

These panels are usually composed solely or predominantly of doctors, who advise potential defendant doctors and their insurers whether to defend or settle claims made against them. Although many medical associations throughout the country have had one of these peer review or defense advisory committees for many years, only the following representative sample was reviewed:

- Idaho Medical Association, "Mediation Committee"
- Maine Medical Association, "Medical Advisory Committee"
- Medical Chirurgical Faculty of Maryland, "Physicians' Defense Committee"
- New Hampshire Medical Society, "Committee on Jurisprudence"
- Oregon Medical Association, "Professional Consultation Committee"
- Rhode Island Medical Society, "Committee on Mediation"

Physician-and-Advisory Screening Panels

In two instances, physicians supplemented their decision-making panel membership by including representatives of other professions:

- Honolulu (Hawaii) Medical Society, "Medical Practices Committee," which includes an attorney and a member of the clergy
- King County (Washington) Medical Society and Seattle-King County Bar Association, "Professional Liability Panel," which includes one member of the local bar association

Medical-Legal Screening Panels

These plans comprise the largest category. Plans listed below, from all known and existing screening panels, were reviewed;

- Alaska Bar Association Medical-Legal Committee
- Pima County (Arizona) Bar Association and Pima County Medical Society, "Medical Legal Plan"
- Maricopa County (Arizona) Bar Association and Maricopa County Medical Society, "Pima Plan for Medical Malpractice Claims"
- Colorado Bar Association and Colorado Medical Society, "Joint Medico-Legal Plan for Screening Medical Professional Liability Cases"
- Joint Medico-Legal Committee of the Delaware Bar Association and Delaware Medical Society, "Joint Medico-Legal Plan for Screening Medical Malpractice Cases"
- Hillsborough County (Florida) Medical Association and the Tampa-Hillsborough County Bas Association, "Joint Medical-Legal Committee"
- South Central Idaho Medical Society and Bar Association of the 4th and 11th Judicial Districts of Idaho, "Joint Medico-Legal Plan for Screening Medical Malpractice Cases"
- Scott County (Iowa) Bar Association and Scott County Medical Society, "Joint Interprofessional Relations Committee of the Scott County Medical Society and the Scott County Bar Association"
- Cumberland County (Maine) Medical Association and the Cumberland County Bar Association, "Medical-Legal Review Committee"
- Androscoggin County (Maine) Bar Association and Androscoggin County Medical Society, "Joint Medical-Legal Plan for Medical Malpractice Cases"
- Montana Medical Association and Montana Bar Association, "Medical-Legal Plan for Screening Medical Malpractice Cases"
- State Bar of Nevada and the Nevada State Medical Association, "Joint Medical-Legal Plan for Screening Medical Malpractice Cases"
- New Mexico Medical Society and State Bar of New Mexico, "Joint Medical Legal Plan for Screening Medical Negligence Cases"
- Legal-Medical Committee of the Nassau County (New York) Bar Association and the Nassau County Medical Society, "Impartial Legal-Medical Advisory Panel"
- Suffolk County (New York) Medical Society and the Suffolk County Bar Association, "Joint Medical-Legal Program for Binding Arbitration of Medical Malpractice Cases"
- Academy of Medicine of Columbus and Franklin Counties (Ohio) and the Columbus Bar Association, "Franklin County Medical Arbitration Plan"
- Montgomery County (Ohio), "Medical Arbitration Plan"
- Berks County (Pennsylvania) Medical Society and Berks County Bar Association, "Joint Medico-Legal Plan for Screening Medical Malpractice Cases"
- Philadelphia County (Pennsylvania) Medical Society and Philadelphia Bar Association, "Professional Liability Consultation Service"
- Joint Medico-Legal Committee of the Medical Society for Virginia and Virginia State Bar, "Joint Screening Panel of the Medical Society of Virginia and Virginia State Bar"

- Pierce County (Washington) Medical-Legal Committee
- Spokane County (Washington), "Medical-Legal Panel for the Review of Possible Medical Malpractice Suits"
- Milwaukee County (Wisconsin), "Medical-Legal Panel Regarding Advisory Determination of Claims Allegedly Arising From Medical Malpractice"

Court-Sponsored Screening Panels

Two jurisdictions have established panels under the sponsorship of the courts for screening medical malpractice claims. Plans analyzed in this category were:

- State of New Jersey Administrative Office of the Courts, "Rule 4:21–Professional Liability Against Members of the Medical Profession"
- New York Supreme Court Appelate Division, First Judicial Department, "Medical Malpractice Mediation Program"

Statutory Plan

Only one state, New Hampshire, has recognized the institution of the screening panel through its legislature:

- New Hampshire Revised Statutes Annotated, Section 519-A:1 to 519-A:10, "Professional Malpractice Claims" (effective January 1, 1972)

Arbitration Plans

Arbitration includes procedures contracted for by the parties, in which they agree to substitute a private forum for the courts for the resolution of their disputes. The following arbitration plans were examined:

- California Hospital Association and California Medical Association, "Hospital Arbitration Regulations" and "Conditions for Admission"
- Southern California Kaiser Foundation, "1971 Amendment to Group Medical and Hospital Service Agreement of the Kaiser Foundation Health Plan, Inc."
- Ross-Loos Medical Group, Los Angeles, California
- Casualty Indemnity Exchange, Denver, Colorado, "Application, Treatment, and Arbitration Agreement"

These arbitration plans vary significantly. Some arise out of a contract entered into by a medical entity and the patient before the occurrence which gave rise to the grievance. Others are activated automatically by the filing of a claim in court. The type and extent of the binding effect of the findings of these arbitration panels also varies to some extent, and there are many other differences. However, since both screening panels and arbitration represent alternatives which are widely used and of significant interest, they are compared in terms of their key procedural characteristics in the discussion which follows.

General Purposes of Alternative Plans

Preventing Lawsuits and Disposing of Just Claims

Screening Panels

The stated purposes of almost all of the screening panels' plans studied are similar to that stated in the Pima County plan:

> "The fundamental purposes of this plan are two-fold. On the one hand, to prevent where possible the filing in court of actions against physicians and their employees for professional malpractice in situations where the facts do not permit at least a reasonable inference of malpractice; and on the other hand, to make possible the fair and equitable disposition of such claims against physicians as are, or reasonably may be, well-founded."

These two purposes are premised on two basic assumptions. First, it is assumed that doctors are injured by unmeritorious malpractice claims which are filed against them. This is widely believed throughout the medical profession and is probably true to the extent that an individual doctor is likely to suffer significant emotional consternation and soul-searching from any suit filed against him, whether or not it is justified. On the other hand, the assumption that a doctor sued for malpractice suffers any real professional or economic harm has not be verified. In fact, at least some doctors and lawyers believe the contrary. The medical profession is likely to coalesce around a colleague unjustifiably sued; and a doctor may even get sympathy from old and new patients who feel he is being unjustifiably prosecuted.

Second, it is recognized that even persons with legitimate medical malpractice grievances have difficulty obtaining expert consultation and testimony. This assumption was verified in the personal interview survey of lawyers under the Legal Systems Study performed for the Secretary's Commission on Medical Malpractice.[35a] The growing use of the doctrine of res ipsa loquitur (where, as its major distinguishing factor, the injury ordinarily does not occur without negligence) also reduces the need for expert medical testimony. Some jurisdictions are even contemplating joining the minority by permitting the use of textbook evidence in place of expert testimony.

Arbitration

The purpose of arbitration, however, is to render a decision on the merits of the claimant's dispute with the medical care delivery entity against which the claim is made—with finality and award of money damages, if justified. In that sense, arbitration also seeks to prevent lawsuits against physicians, for many of the motivations which are apparent or implicit in the establishment of screening panels are also inherent in the arbitration plans. One frequently articulated virtue of arbitration is that its inherently simpler procedural and decision-making attributes, as contrasted with an action at law, will allow claimants with only small claims to obtain a just settlement. More frequently, however, it is asserted that arbitration will make money damage awards more uniform through the greater sophistication of the arbitrator, who is less likely than a jury of laymen to be swayed by sympathy for grievous injuries.

[35a] "The Medical Malpractice Legal System", *Supra*, p. 00.

Limiting Publicity

A third purpose which is generally implicit, if not stated, in the rules of almost all of the screening panels (and in the arbitration plans as well) is to limit publicity. Doctors commonly believe that publicity accompanying medical malpractice litigation is damaging both to the doctors involved and to the medical profession as a whole. Some lawyers, on the other hand, argue that the increased publicity has forced doctors to be more careful and, by and large, to improve the quality of medical care. Unfortunately, there is no clear evidence available to prove which of these positions is more correct, and logical arguments can be made in support of both. It has been observed that in jurisdictions which have an active malpractice press, the panels are strongly supported. In others, agreements to withhold press coverage until after the full determination of the case have been successful.

Privacy of the proceedings may encourage a more open and candid disclosure of relevant information, thereby facilitating the resolution of medical malpractice claims. On the other hand, publicizing enough details of the basis of the claim and the decision of the panel should help other doctors and patients to recognize developing and improving standards of medical practice. Of the many screening panels and arbitration plans studied, only one—the Hawaii panel—had implemented a "feedback" of information to the medical community at large, through the annual report to the membership.

There are ways other than screening panels and arbitration, however, by which the medical community may limit publicity in actions brought against physicians. During investigation of the Colorado Medical-Legal Screening Panel, an attempt was made to ascertain from the court records in Denver a representative sampling of medical malpractice actions at law. This research was frustrated upon discovery of the following motion and order in the first case found:

> *MOTION TO SUPPRESS*
> The plaintiff moves the court for an order on the following grounds:
>
> 1. This is an action alleging medical malpractice.
> 2. Plaintiff is informed and believes that Denver metropolitan area news media and Denver Medical Society have an agreement under which there is to be no publication of any kind of facts alleged in actions of this matter prior to the trial date.
> 3. Any unnecessary publication of matters in this complaint would unnecessarily embarrass and invade the privacy of the plaintiff.
> 4. The plaintiff is merely seeking compensatory damages for the death of her late husband and she does not desire unnecessarily to injure the general reputation of either of the defendants.
> 5. The plaintiff is informed and believes that, in the public interest, it is more likely that this action may be settled amicably and without a lengthy and expensive trial if the facts alleged in the pleadings are not divulged or publishbed prior to the trial.
>
> WHEREFORE. .
>
> *ORDER - SUPPRESSING PUBLICATION*
> The Court, having considered the matters set out in the plaintiff's motion to suppress publication, and having heard the arguments of counsel and being fully advised, it is
> *ORDERED* that publication of all matters set out in pleadings or other documents in the files of this case shall be and is hereby forbidden until further Order of the Court.

There are intriguing First Amendment questions involved in the action of the Colorado court in issuing its order and the underlying factors by which the agreement was reached between the "Denver metropolitan area news media" and the Denver Medical Society. It would seem that the proper moving party for a motion of this type would be the defendant rather than the plaintiff. The researchers were informed that motions in the form of the above-quoted example are contained in all actions at law alleging medical malpractice.

The allegation in the motion that publication would embarrass and invade the privacy of the plaintiff seems simply a legal fiction by which the plaintiff gains standing to assume the role of the moving party. The portion of the motion indicating that no malice is borne by the plaintiff in bringing the action and that there is no desire unnecessarily to injure the general reputation of the defendants would seem only a self-serving statement that an action is brought in good faith. The concluding paragraph of the motion, that the action may be settled more amicably without publicity, is undoubtedly true; but it is difficult to conclude, as does the plaintiff in her motion, that to do so is in the public interest.

The practice of sealing files under court order is widespread in juvenile and domestic matters as well as actions in tort, alleging criminal conversation, seduction, alienation of affection, and the like. There are sound public policy reasons for limiting the publicity given to lawsuits dealing with scandalous matters. However, a medical malpractice action is not of the same class or dimension of scandal. The competing policy interest of a free and open public trial of issues in which there is a public interest and the interest of creditors in being able to disclose from public records who is suing or being sued must be weighed in the balance.

This suppression of activities in the judicial process, either through motions to suppress publication or "John Doe" or "XYZ Corporation" style cases, should be the subject of inquiry and comment by those interested in protecting the public's traditional right-to-know.

Stated Unique Goals of Arbitration

In addition to the purposes described above, to which all the screening panels subscribe, arbitration plans also strive to:

- Speed the handling of claims;
- Save the time and expense of doctors, lawyers, witnesses, and courts;
- Ensure a high degree of sophistication in decision-making;
- Minimize unnecessary appeals; and
- Limit the amount of verdicts or awards.

Only the last of these stated goals is open to debate, since it presumes that jury awards are unreasonably high. However, many trial lawyers contend that jury awards are a good reflection of the attitude of the community in this field.

Observed Limitations of Alternatives to Litigation

Unfortunately, all of the stated purposes in both the screening panels and arbitration plans fail to emphasize the greater needs of society. In particular, they do not set for themselves as explicit goals:

- Encouraging better quality medical care;
- Reducing the overall cost of litigation and insurance which is passed on to patient consumers;
- Reducing the burdens on the court systems; and
- Encouraging a more economical and therefore more equitable opportunity for parties with legitimate grievances to get fair compensation.

Any model plan should not only emphasize these objectives in its stated purposes, but should also strive to achieve them through the structure of its procedures.

How Plans Are Formed

Screening Panels

No conflict-resolution mechanism merely happens. Most of the screening panels have been initiated, instituted, and administered by the voluntary cooperation of the local bar association and medical society. Since the success of the plans hinges to a large extent on the cooperation of these organizations, it is understandable that they should be instituted and administered in this fashion. However, an opportunity exists to shield from public view what, in the opinion of some commentators, should be made public. In the main, all work by the physician and attorney participants is without fee.

Physician screening panels usually arise out of a need for communication between the physicians and insurance companies. That is, the physicians participate in the decision as to whether a case is defensible, and thus are active in the process whose results have a direct bearing on the size of their premiums. The insurance company also benefits from the medical expertise provided to defense counsel. The Hawaiian panel is unique in that it grew out of the medical society's "peer review" committee, in which physicians institute a review of the conduct of their members upon legimate complaint. Thus, the screening of malpractice allegations was a logical extension; this fact best explains the many unique features of this panel.

The Pima County plan, instituted in 1957, was the earliest of the screening panels. Some of the more recent plans have been instituted either by rule of court (as in New Jersey) or by legislative enactment (as in New Hampshire). The advantage of these more compulsory methods of initiation is that they are funded and administered by existing state organizations, have better potential uniformity in their application, maintain controls on potential abuses, and provide broader jurisdiction over parties.

Arbitration

All of the arbitration plans were formed by the medical entities or insurance carriers sponsoring them, with the objective of gaining some control over the cost of malpractice insurance—by eliminating large sympathy verdicts, shortening the time to resolution, and making claims easier and less costly to defend.

Makeup of the Panels

Size and Composition

The screening panels vary considerably in size and composition. Many of the plans have both permanent panels ("pools" from which members are drawn for hearings) and specially designated hearing panels which may also vary in size and composition. The following discussion of procedural attributes, however, is confined to hearing panels, rather than permanent panels. There is a variety of ways in which members are chosen, of attempts to include expertise on the panel, of provisions for disqualification, and of panel member terms.

Screening Panels

Most of the screening panels follow the Pima County plan, with equal numbers of doctors and lawyers. On screening panels which have as their objective the defense-advisory function, only doctors are voting members. The Hawaiian panel includes a clergyman as a voting member; however, this is quite unique. Three plans have an equal division of lawyers and doctors on the panel, plus a chairman who may be either a lawyer, former judge, or member of the medical society or bar association. The New Hampshire statutory plan (designed to hear medical, dental, and legal malpractice claims) includes one layman, one professional member (representing the profession to which the defendant belongs), and one judicial referee—an associate justice of the trial courts or a master appointed by the court.

The size of these screening panels varies considerably; many, including the Pima County plan, have as many as ten to twelve members. While there is as yet no quantitative evidence to indicate what significance the difference in sizes of the hearing panels has on their utilization or outcome, logical deductions can be made. The larger panels have a greater likelihood of including the relevant expertise and perhaps are less subject to biases. However, they are more costly to administer (in an imputed cost sense), are more difficult to assemble, and may result in greater peer pressure being exerted on the panel members.

Arbitration

The determination of size, composition, and designation of the arbitration plans is significantly different from the procedures used in organizing the screening panels. The smallest arbitration panels have one arbitrator.[36] Even the largest of the arbitration panels, however, is substantially smaller than the larger screening panels. Presumably, the smaller size facilitates the rapid case presentation and decision-making that must take place in arbitration. It is also a reflection of how the different types of plans were initiated and are administered; the ones operated by the American Arbitration Association have fewer constituents to satisfy and a greater need to economize on their manpower resources than do the screening panels run by the bar associations and medical societies, or medical societies alone.

How Members Become Available for Hearings

Screening Panels

As important as the size and theoretical make-up of the hearing panels is the pool from which the members are drawn. In most of the screening panels that include equal numbers of lawyers and doctors, these members are drawn from their respective bar associations and medical societies. In most cases, they are appointed by the president or medical-legal committee chairman of the respective organization, or else they are elected in conformance to bylaws of the organizations. Sometimes the screening panels are designated from the medical-legal committees of the bar and medical associations. To the extent that the hearing panel members are appointed or elected in light of their particular expertise, objectivity, and impartiality, they are more effective members. However, there is no way to ensure the quality of this type of selection method.

The few screening panel plans that are operated in conjunction with the courts (e.g., New York, New Jersey, and the New Hampshire statutory plan) have lists of panel members maintained by the courts and sometimes chosen by the courts or by lot. A number of plans including, for example, the Franklin County (Ohio) plan and the Montgomery County (Ohio) plan, make a special attempt to designate a medical specialist who is knowledgeable about the medical problems that may arise in a given case.

The Franklin County plan and the Montgomery County plan have a unique method of selecting screening panel members. They use the offices of the American Arbitration Association to submit the names of possible members to the parties, who may reject any or all of the names initially submitted. Selection of the final panel may thereafter be made by the American Arbitration Association from remaining possibilities on the list of willing doctors prepared by the presidents of the Academy of Medicine/Medical Society and the list of willing lawyers prepared by the presidents of the bar associations.

Arbitration

Generally speaking, the arbitration panels are selected in one of two ways. The traditional manner, exemplified in the Ross-Loos and Kaiser Foundation plans, is for each party to select a partisan arbitrator; then the two partisan arbitrators agree on a neutral arbitrator. This method has been criticized for its tendency to encourage a compromised decision rather than a reasoned one, since only the neutral arbitrator really has any flexibility to decide the case on its merits, and even he is pressured by the two partisans to settle on a negotiated basis. A second way of designating arbitration panel members, which is gaining growing support, is exemplified by the Southern California Hospital Plan. This plan utilizes the administrative support of the American Arbitration Association, which provides identical lists of potential arbitrators to all parties. The parties then have seven days to number the list by preference and object to anyone on it. The numbered lists are then matched to select arbitrators who are agreeable to all parties. If no matching is possible on the first list, new lists are submitted to the parties until agreeable arbitrators are selected. This method is similar to the one used by the Franklin County and Montgomery County screening panels, which are also administered by the American Arbitration Association.

Attempts for Expertise

Screening Panels

Those plans which do not explicitly provide for the appointment of medical experts to a given hearing panel may still have an opportunity to ensure that the panel is given adequate expertise. For example, many of the plans follow Pima County's lead in permitting the majority of the permanent panel members to appoint any additional lawyers or doctors to a given hearing panel, and most plans permit the hearing panel to call expert consultants. Since the success of most of these screening panels hinges on the general quality and cooperation of the panel members and their respective medical and bar associations, they are generally carefully selected by their respective organizations.

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[36] See, J. Ludlam and H. Hassard, "Arbitration," *Hospitals* 44 (October 1, 1970), p. 58.

Arbitration

Arbitration panels chosen from lists of names provided by the American Arbitration Association generally provide less expertise than the screening panels since there are fewer members and there is less concern with their expertise and more concern with their agreeability to the parties. However, the lists used to select the arbitrators may be lists of health experts or knowledgeable lawyers and not merely random names. There is considerable concern by the spokesmen for widespread use of arbitration in the medical malpractice setting as to where qualified arbitrators would be found if needed in great numbers.

Procedures for Disqualification

Screening Panels

The Pima County plan has the most elaborate provisions for disqualification of panel members. They are expected to disqualify themselves if they have any personal or official connections or if they feel their presence is for "any reason inappropriate."[37] In addition, a panel member may be challenged by a party for cause at any time prior to taking of testimony at the hearing; final ruling on this challenge is made by the medical and legal chairmen or by a majority of the other members if the chairmen on the hearing panel cannot agree. Finally, under the Pima County plan, each party is entitled to two peremptory challenges as long as they are used within five days following receipt by counsel of the names of the members of the panel.

The Maricopa County plan is identical to the Pima County plan, and the Nevada plan has nearly identical provisions for disqualification. Almost all of the remaining screening panels which are similar to Pima County provide for the same kind of self-disqualification but make no explicit mention of disqualification for cause or peremptory challenge.

Arbitration

In light of the way most arbitration panels are selected, there is no need for explicit disqualification provisions since this can be done in a way analogous to peremptory challenges by the parties refusing to consent to an arbitrator. The selection process also implies that the arbitrators merely serve for the duration of a given case.

Term of Members

Screening Panels

Most of the screening panel plans make no explicit provision for the term of the hearing panel members. It is implied, however, that the hearing panels (unlike the permanent panels) are designated from case to case for the duration of a specific case. There are a few plans, however, which stipulate that the hearing panel may be appointed for as long as three or four years.

Arbitration

Arbitration panels meet only to decide the controversy which they have been selected to hear.

Initiation

There are a number of procedural dimensions by which alternatives to litigation operate. It is in these rules of procedure that they differ most remarkably from an action at law, by providing for simple, and yet effective, machinery to resolve or determine the merits of a dispute.

Events Necessary To Activate

Screening Panels

Most of the screening panel plans follow the lead of Pima County in requiring merely that the claimant and his attorney file a written and signed request for the panel to consider a claim. A few screening panels require both the claimant and the defendant to consent to the panel before it will proceed. The Suffolk County (New York) plan provides that the claimant, defendant doctor, and his insurer as well must agree before the proceeding is held.[38] A number of physician screening panels will meet and determine whether to settle or contest a potential claim simply upon the assertion of the physician that he may have committed an act of medical negligence. This procedure apparently is never communicated to the injured patient. The Hawaiian plan will even hear cases which are not known to the physician involved, although this is an extreme case.

Arbitration

Arbitration plans vary considerably in terms of the procedures used for activating the panel. Most provide that any party to the arbitration agreement may demand arbitration and thereby activate the process. Occasionally, in practice, the activating event is the filing of a lawsuit which results in automatic reference to arbitration. All of the arbitration plans involve a contract to arbitrate which is entered into before any claim arises. While some of these plans have taken elaborate drafting precautions to avoid the many challenges to the enforceability of the arbitral agreement, there is still an inherent probability that, because the patient may place his name on a contract to arbitrate medical malpractice claims without consciously agreeing to or fully understanding the import of the agreement, the courts might not enforce it.

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[37] This articulated standard in Pima County for screening panel self-disqualification may be even higher than for actions at law. In one case in which the Pima County Screening panel found the defendant negligent, a subsequent trial by jury rendered a verdict for the defense. Plaintiff moved for a new trial based on proof that a juror—an attorney and a member of the medical-legal panel—had a "faint recollection" of the case. Motion denied.

[38] In Pima County, a few cases were noted in which the doctor's insurance company "refused" to permit his attendance at the panel. The doctors hired their own lawyers, went to the panel hearings, and the claims were dropped.

Costs for Filing and Preparation

Screening Panels

Although most of the screening panels do not have any explicit costs for filing or other preparatory costs, a few do require minimum filing fees, generally $50, merely to defer the expense of administration. This expense is slightly higher when assisted by the American Arbitration Association. Costs of case preparation to the litigants, such as attorneys' fees, are not addressed in the rules of any plan. The Pima County plan, however, has the important and unique provision in that it makes an expert witness available to the claimant, without charge, for preparing the presentation of the claim to the panel.

Arbitration

Arbitration plans which use the American Arbitration Association typically require a stipulated filing fee, although this is still minimal in amount. The Southern California Hospital plan, for example, requires each party to pay $150; however, this can be waived in hardship cases. The other arbitration plans which operate under the California Arbitration Statute without the services of the American Arbitration Association (for example, the Kaiser Foundation plan) have no stipulated filing fee. There are no explicit provisions for other preparatory costs, but it is generally noted that arbitration requires no more than one day of hearings and perhaps less formal preparation than litigation. In addition, the use of hearsay evidence (medical textbooks) in arbitration proceecings has the potential for greatly reducing the cost for expert witnesses. An attorney, however, who relies on his own medical knowledge, gleaned from textbooks, might well work his client a disservice, especially when opposed by a "live" and knowledgeable expert provided by the defending insurance company. In this event, arbitration perhaps encourages less than full advocacy.

Pleadings

Screening Panels

When a claimant decides to request a panel review of his case, he must generally submit a written request, including:

- A brief statement of the facts, including the persons, dates, and circumstances known;
- A request that the panel consider the merits and give a report; and
- A statement that the lawyer has read and subscribes to the screening plan, and that the client agrees to the submission of the facts pursuant to that plan.

Although these pleadings are neither technical nor strict in their requirements, they are the primary basis upon which the panel makes its review. However, each panel seems to decide for itself on an ad hoc basis whether or not it will assist the claimant in articulating his legitimate grievances, when he has presented an alleged claim for which he has no proof but failed to present the claim for which the panel believes he may have proof. None of the plans have explicit provisions dealing with this matter, but informal conversations with officials of various panels have indicated a variety of approaches to this problem.

With informal rules of pleadings and an asserted aim ". . .to make possible the fair and equitable disposition of such claims against physicians as are, or reasonably may be, well founded," simple justice would seem to require that should a claimant present a reasonable set of facts substantiating a claim for negligence or reasonable evidence of it, the panel should make this fact known to him. Although the plans state this noble purpose, that is not always the result. Many are not as liberal as courts of law under modern rules of civil procedure which allow amendment of pleadings should proof fail to conform to them and yet substantiate an adequate legal theory.

The New Mexico plan is most strict on its face in regard to construing the pleadings and requiring formal amendments to them, yet this panel will not entertain any written briefs. Poorly framed complaints, however, were widespread in both actions at law and screening panel records studied.

Arbitration

There are no explicit provisions dealing with pleadings in most of the arbitration plans.

Agreements and Waivers

Screening Panels

Perhaps the most significant element of the procedures for activating the panel are the agreements and waivers which one or both of the parties and their lawyers must make in order for the panel to proceed. Under the Pima County plan, which is most frequently followed, the claimant must give written authorization for the panel to obtain access to all his medical and hospital records pertaining to the incident and he must waive his privilege as to the contents of these records strictly for the purpose of the panel's consideration of the particular case. Such a waiver is reasonable in order to permit the panel to have access to the relevant records and to make an intelligent determination. Those panels which require the doctor to give his consent usually also require him to authorize review of any relevant medical records which are in his control (Hillsborough County, Florida, for example).

Almost all of the screening plans emphasize that the parties and other participants must agree to the confidentiality of the proceedings. Accompanying the agreement is a promise by the parties that no panel member will be asked to testify as to any of the panel proceedings. The purpose of these agreements is to ensure the open and candid participation of both claimants and doctors. It is also an attempted safeguard against a claimant trying to use the panel as a discovery mechanism. This is a rather unique point of view in that all modern rules of civil procedure now encourage and permit elaborate discovery procedures on the theory that when, and only when, the parties know the full extent of the facts of the other's case, they will be in a position to negotiate for settlement productivily or try their cases fairly. This is in furtherance of a proposition that lawsuits should not be won on the basis of surprise and that the ends of justice are best served when both parties are able to present their cases with fair and informed advocacy.

Some of the plans go further than the Pima County plan and require that no reference be made in future legal proceedings to any statements or evidence prepared exclusively for the hearing panel. The proceedings of the Hawaiian plan are immune from subpoena by statute. The Scott County (Iowa) plan also requires the claimant to waive all claims against the committee or its members for libel, slander, or defamation in connection with the panel proceedings. This provision, illustrative of super-cautious drafting, should perhaps be bilateral rather than unilateral.[39]

Related to this issue of confidentiality is the frequent agreement that none of the proceedings or the participants to those proceedings may be admitted into evidence in later legal proceedings. For example, the New Mexico plan has the added proviso that the parties must consent that "no attempt will be made to use as impeaching evidence in court any statement made by any person during a hearing before the panel." Since procedures before the panel are so much more informal and different from those before a court and are in the nature of settlement negotiations, most screening plans seem to assume it would be inappropriate and a violation of established rules of evidence to permit any of the information developed in the panel proceedings to be admitted into later court litigation. One 1965 Nevada case, however, in an interpretation of the panel's rules, held that a party's statement before the panel could be used to impeach that party in subsequent court litigation; whereupon the rules of the panel were more carefully drafted.

This issue between secrecy and a quasi-settlement negotiation characterization of panel proceedings must be balanced against rules of evidence which permit the introduction of hearsay statements of admissions-against-interest made by party opponents, and the foundation of the trial of an action at law which is to find truth. Since the proceedings during screening panel hearings are not under oath, the temptation might arise to be less than candid during panel proceedings. It would seem that the better view would be to allow the use of such evidence, at least for impeachment purposes, rather than to risk perjured testimony.

A few of the screening plans that deviate significantly from the Pima County model include additional waivers or agreements designed to enhance the effectiveness of the panel, make it more attractive to the parties, and anticipate such problems as legal incompetence, the running of the statute of limitations, and the suspension of legal proceedings during the time in which the panel is hearing the claim.

For example, the King County (Washington) plan stipulates that the claimant must submit to an examination by panel members if requested; his refusal to submit may be held against him. It should be recalled, however, that this plan is essentially composed of physicians.

The New Jersey plan provides that the claimant may, but need not, agree to be bound by the panel's decision if it is against him. If he agrees, he is ensured of getting the names of three medical experts who will testify for him if the panel decides in his favor. However, he may withdraw this consent before the hearing begins.

The Franklin County (Ohio) plan has a unique provision which requires all claimants, including those with companion claims (such as the spouse or parent), to agree in writing to be bound by any adverse finding of the panel; and the guardian of a minor or incompentent or a representative appointed by the probate court must likewise agree and obtain the approval of the probate court before the panel will proceed. Furthermore, the doctor and his insurer may agree to suspend the statute of limitations until 90 days after the panel hands down its ruling.

The Suffolk County plan requires that the trial court in New York give an order approving submission of the case to the panel if the claimant is an infant. Furthermore, this plan stipulates that if any legal action is commenced by a party relating to the case before the panel, the moving party becomes responsible for attorney fees and other expenses of the panel, its members, or the bar and medical associations defending such action. Additionally, the claimant and the defendant doctor and his insurer must consent to waive all rights to litigate any of the same issues before the panel except those which the panel could not decide.

Finally, the Berks County (Pennsylvania) plan deviates from the Pima County model to the extent that the claimant must promise not to use any discovery procedures against the defendant doctor in his case for 60 days from the time he refers the case to the panel.

Arbitration

Arbitration plans generally have fewer provisions dealing with agreements or waivers, since the very agreement to arbitrate implies a host of waivers, including the waiver of a jury trail. The Southern California Hospital plan specifically provides that there is no waiver of the statute of limitations by pursuing the claim under the arbitration procedure.

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[39] See, J. Carlova, "He Sued His Malpractice Plaintiff for Libel—and won," *Medical Economics* 106 (June 1971).

Jurisdiction

Over Geographic Areas, Subject Matter, and Persons

Screening Panels

Most of the screening plans follow the Pima County lead of taking jurisdiction only over a member of the medical society, his servants, agents, or employees, and over any alleged act of professional negligence occurring in the geographic location in which the panel and its administrative bodies have jurisdiction by their by laws.

Most of these panels, like Pima County, also limit their jurisdiction to the medical malpractice cases based on the theory of negligence, and explicitly exclude covering cases involving a contract theory, intentional torts, or cases where expert medical testimony is not needed, through application of the legal doctrine of res ipsa loquitur, where the negligence is obvious.

An interesting quandary arises in the case of those plans which preclude from their jurisdiction the hearing of intentional tort claims, for frequently arising in the medical malpractice claims arena is the allegation of battery based on the lack of informed consent. Even though the panels specifically exclude intentional tort cases from their jurisdiction, informed consent issues dealing with claims based on this theory of battery are universally heard by the panels, generally because the standard of the amount of information supplied a patient to obtain his consent is, in most jurisdictions, a medical question.

A few of these screening plans (Androscoggin County, Maine, and Nevada) permit review of medical malpractice cases arising outside their geographic jurisdiction although dealing with doctors who are members of their medical societies. Generally, the claimant and his lawyer must also be from the county or state in which the particular panel has jurisdiction, although a few panels (e.g., King County, Washington) will hear claims presented by claimants from outside their jurisdiction against doctors from within their jurisdiction.

A few screening plans also take jurisdiction over hospitals or other health practitioners like dentists, but generally only if such potential defendants' organizations have agreed to the plan in advance of any claim being filed under it. This is the case under the experimental program in the New York Supreme Court, Appellate Division. Interviews with some of its participants, however, suggest that plan has yet been unable to settle a claim against a hospital due to an inability to find an individual in the city bureaucracy within Manhattan with the authority to do so.

This tendency toward widening the jurisdictions over the corporate and individual persons within a geographic area has wide potential for reducing claims against physicians when joined with a corporate entity. This facet has been recognized by the Colorado plan, and it is a conclusion of this study that screening panels would be far more effective if a significant proportion of the hospitals and medical services groups within a jurisdiction were encouraged and permitted to avail themselves of the screening panel procedure.

Jurisdiction over parties often presents a problem to those plans which require the consent of both claimant and defendant. This is the case, for example, in Milwaukee County (Wisconsin) and Franklin County (Ohio). These few plans which require the consent of both claimant and defendant limit their jurisdiction to those participants who grant their consent to the proceedings.

Having taken jurisdiction over the relevant persons and geographic area, at least one of these screening panels, the Franklin County (Ohio) plan, reaches out to cover the subject matter of all grievances, including contract disputes between the claimants and defendants.

Arbitration

The jurisdiction of the arbitration plan tends to be broader and in some instances can be said to transcend the jurisdiction of the courts of the same locale. Arbitration, for example, could include claims in contract and tort, where in a few jurisdictions they may not be joined in the same action at law, or controversies not justiciable in an action at law. Generally, contracts of arbitration provide that the arbitrator shall have jurisdiction over all claims, including contract and other claims, as well as medical malpractice claims. The arbitration plans also have jurisdiction over all parties who consent to arbitration, either by prior contract or written agreement, once the arbitration has begun. This is the case, for example, in Suffolk County, New York, when it is acting in its capacity as an arbitration board rather than a medico-legal screening panel.

In Pennsylvania, there is an arbitration plan not limited to medical malpractice disputes, but a statutory small claims procedure, which may not consider any claim over $3,000. An arbitration plan in Pennsylvania would face the decision whether its jurisdictional amount would exceed or be concurrent with the arbitration statute. On the other hand, under the Southern California Kaiser Foundation plan, the panel will not hear a claim unless damages exceed the limit of the small claims court. Generally, other jurisdictional issues under the arbitration plans are regulated by the arbitration statutes of the state in which the arbitration agreements have been made.

Effect of Pending Litigation

Screening Panels

A pending court case has no effect on the jurisdiction of screening panels under most of these plans. Only three screening panels (the Delaware, Scott County (Iowa), and Virginia plans) prohibit the hearing of a case if it has been filed in court, based upon the plan rules. Other plans discourage the filing of actions at law until the panel has acted.

The New Mexico plan notes one effect of a pending court case by stating that the filing of the claim with the panel may qualify it for coming within the statute of limitations even if it has not yet been filed in court. This provision encourages the filing of claims with the panel before filing them in court without fear of losing the timeliness of the claim.

This extra-judicial adjustment of the rules of law, however, may be fraught with unforeseen dangers. If a party defendant refused to recognize the jurisdiction of the New Mexico plan, which has no statutory foundation, it is questionable whether the unilateral act of the plaintiff would obtain for the plaintiff the benefit of the interruption of the statute of limitations. If the defendant physician responded, however, it is likely that he would be estopped from pleading the statute in bar should a later action at law be filed.

Unanswered is the question of how the New Mexico courts might deal with a situation where a plaintiff, who might be seeking to gain an extension of the statute of limitations for the purpose of allowing damages to mature with greater certainty, filed his claim before the New Mexico panel and then failed to pursue it vigorously. The provision of the rule, however, and its foundation and purpose, which suggests that the objective of the New Mexico plan is to prevent the filing of lawsuits against physicians, are noteworthy. No decided case was discovered dealing with the recognition of whether the filing of a claim before an extra-judicial forum would interrupt the running of the statute of limitations. In the majority of jurisdictions, the attorney does not rely on the panel for timely filing but files the action at law.

Arbitration

In general, parties are free to arbitrate a dispute when they contract to do so. It is therefore the result that an existing agreement to arbitrate a claim will definitely affect pending litigation, but pending litigation has no effect on the making of contracts to arbitrate.

Prehearing Procedures

Discovery and Other Preparation

Screening Panels

The Pima County plan provides the most extensive and seemingly favorable provisions for authorizing discovery and other types of assistance in preparation by the parties and the panel for the panel hearing. In particular, the claimant's authorization for the panel to get access to the medical records, along with his original letter request and any answer provided by the defendant doctor, are all made available to the panel. In addition, the medical chairman is required to furnish the claimant with the names of three specialists and the claimant may choose one with whom to discuss his case frankly, without compensation. The specialist is directed to cooperate for the purposes of the hearing and to maintain a confidential relationship with the claimant.

Most of the other screening panels do not provide such expert consultation to the claimant ahead of the panel decision, and their discovery authority and material is limited primarily to the claimant's request and pleadings and authorization to supply the records. The New Hampshire statutory plan and the New Jersey plan deviate to the extent that they permit discovery and the right to subpoena witnesses and evidence as in other judicial proceedings. Under the Franklin County plan, it has been reported that panelists operate under the privileged status of arbitrators under Ohio law and can therefore issue supoenas.[40] Only the Berks County plan explicitly prohibits the claimant from using discovery against the doctor in the case (for 60 days) from when the claim is referred to the panel.

Arbitration

Since arbitration serves as a substitute for litigation rather than a predecessor of litigation, parties generally have the same scope of discovery as in an action at law. This tends to present greater opportunities for prehearing settlement, but is more costly and time-consuming than with the screening panels' informal discovery procedure.

Opportunity for Summary Disposition or Settlement

Screening Panels

The Pima County plan is one of the few to contain an explicit provision dealing with prehearing opportunities for summary disposition or settlement. It provides the opportunity for a prehearing conference between the counsel for both parties, if either or all desire, and if the legal and medical chairmen recommend it; but this prehearing conference is not compulsory and the panel is not allowed to make any effort to settle or compromise the claim.

The Montana plan has an identical provision. A few of the judicially sponsored screening panels may try informally to urge the parties to settle even before they bring the case before the hearing panel. This is the case in the experimental program conducted by the New York Supreme Court, Appellate Division, in Manhattan. It is reported, however, that the actual operation of this facet of procedure is dependent almost entirely on the temperament of the presiding judicial officer.

Arbitration

Many defenders and supporters of arbitration believe that the arbitration process itself creates a unique psychological incentive for achieving settlement prior to the actual hearing. They note that the more immediate deadline that accompanies an arbitration proceeding creates this incentive which is lacking in prolonged and delayed litigation processes.[41] Reported experience at Ross-Loos suggests that only three or four cases have been arbitrated, since almost all of the others brought under this plan have been settled before the deadline. Whether this experience of Ross-Loos is due to the impending deadline for arbitration or is simply representative of dispute resolution, as found in the action at law, cannot be evaluated accurately. This question might be susceptible to analysis when the Insurance Closed Claims Study being prepared for the Secretary's Commission on Medical Malpractice has fully analyzed its data. Preliminary examination, however, of reported unweighted samples indicates that the settlement profile reported for Ross-Loos is similar to that for all types of claims-handling behavior, and that arbitration per se introduces no unique feature into the claims settlement process other than to simplify the hearing phase of dispute resolution.

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[40] R. Coulson, "The Malpractice Mess: Is Arbitration the Answer? *Medical Times of Port Washington, New York,* 131 (October 1971), p. 99.

Time

Screening Panels

The time spans from the filing of the claim to the hearing vary from one panel to another. Nevertheless, generally there is some provision which attempts to limit the duration. Some panels, like the Pima County plan, stipulate that the hearing must be held within 60 days from the filing of the claim unless there are extraordinary circumstances. Some screening panels, such as Androscoggin County (Maine), Idaho, Nassau County (New York), and Virginia, require a hearing to be held within as few as 45 days after the request is filed. Most of the screening panels, however, have some provision for a supplemental hearing within 15 days after the original hearing and permit continuance of the case if the parties and their counsel so stipulate. While there are minor variations, most of the panels either explicitly limit the time span or else report informally that the time span between filing of the claim and hearing of the claim is less than two or three months. However, these ambitious schedules are hardly ever achieved.

Arbitration

Although the use of arbitration in third-party liability claims has been reported as usually achieving final judgment in less than three months,[42] the informailty of the arbitration proceedings generally result in continuances if the parties agree and there appear to be legitimate reasons for it.

Procedures During Hearings

All of the alternatives to litigation provide for informal procedures during the hearing. The various plans then modify their proceedings in light of the outlook and experiences of the panel members and participants before the panel. However, most of the plans do make some reference to a host of procedural questions, including: requirements of oaths, right of confrontation, right of cross examination, presence of the parties and their counsel, rules of evidence, witnesses, secrecy during deliberations and voting, and transcript or record of proceedings.

Procedural questions regarding arbitration will not be addressed in this section for they are discussed in detail in "Alternatives to Litigation: III."[43]

Requirement of Oaths

New Hampshire's new statutory plan is the only plan explicitly requiring the taking of oaths for the presentation of evidence to the panel. Most of the plans make no mention whatsoever of oaths. New Jersey and the Franklin County plans do provide that a party may submit sworn statements. All of the other screening plans are silent on the question of oaths.

Right of Confrontation and Cross Examination

Trial lawyers view cross examination as the best technique for getting at the heart of conflicting issues and uncovering the truth. Most doctors, however, consider it a brutal, misleading, and unnecessary way to come to an understanding and resolution of highly technical medical facts. One of the articulated reasons doctors are said to be looking for these alternatives to litigation is to avoid some of the trauma of being subjected to cross examination.

All screening panels which permit the parties to be present during the presentation of the opposing side implicitly accept the right of confrontation. Some of them, like the Pima County plan, permit the panel to use its discretion in dismission opposing parties and their counsel if the panel chooses to question a party or witness separately. None of the plans, however, explicitly asserts a right of confrontation.

Most of the screening panels permit cross examination of both the claimant and defendant, and witnesses. However, it should be noted that those panels which may dismiss parties or their counsel to ask an individual questions undermine any formal right of cross examination. The right of cross examination that does exist in these screening panels is more restricted than would be true in court litigation. The Delaware, Berks County, and Virginia plans are silent on the question of cross examination, and seven plans explicitly renounce any right to cross examination.

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[41] "The Experience of Binding Arbitration in the Ross-Loos Medical Group in Los Angeles, California," *infra,* pp. 424 ff.

[42] H. K. Santoorgina, "Arbitration of Third Party Liability Claims: One Company's Experiment," 2s *The Arbitration Journal*, 24 (reprint 1969) p. 3.

[43] *Infra*, pp. 321 ff.

Almost all of the screening panels (except for physicians' defense committees) permit the parties and their counsel to be present during presentation of the claim and the defense. Similarly, almost all screening panels follow Pima County in prohibiting either the parties or their counsel from being present during the deliberations and vote of the panel. There are only three exceptions—the Idaho, New Mexico, and Spokane County (Washington) plans. The Idaho plan does not explicitly authorize the claimant or his counsel to be present during the presentation of the defense. While usually the Idaho panel permits the claimant and his lawyer to be present, it sometimes excludes them when the defendant or his insurer strenuously objects and may refuse to cooperate with the panel if the claimant or his counsel is present. The New Mexico plan stipulates that counsel may be present during both claim and defense presentations, but opposing parties may not be present unless the panel so authorizes. The Philadelphia County screening plan requires that the claimant present his claim and be questioned by the panel in private, and that the defendant likewise present his defense and be questioned in private.

Rules of Evidence

Informal rules of evidence are seen to be one of the most frequently articulated advantages of both arbitration and screening panel alternatives to litigation. While this informality and flexibility should be encouraged, the panel should have the discretion to impose some rules of evidence to ensure the orderliness of the proceedings and to increase the likelihood of uncovering relevant information. Nevertheless, there is no need for elaborate hearsay or other rules of evidence, since it is presumed that the more sophisticated hearing panels will be able to weigh the reliability of the evidence presented. Furthermore, the medical experts on the panel should perhaps be encouraged to assist a claimant who apparently has a legitimate grievance but has failed to articulate it properly in his pleadings. Justice would seem to require that there need not be any strict requirement that the claimant's proof conform to his pleadings.

Since screening panels do not operate under strict rules of evidence, particular rules may vary from one panel to another. Almost all of the plans follow Pima County in giving the legal or medical chairman discretion to limit testimony to what he determines "relevant and material" to the issue. Most of them also follow Pima County's order of presentation of a case, which includes:

- Claimant presents his case.
- He is cross examined or questioned.
- Defendant present his case.
- Defendant is cross examined or questioned.
- Witnesses testify and counsel questions them.
- Panel deliberates.
- Panel may recall parties or witnesses for further questions.
- Panel deliberates and either votes or requests a supplemental hearing to be held within 15 days.

A few of the screening plans suggest that the claim and defense be limited to about one hour. The Franklin County plan deviates to the extent that it provides that the commercial arbitration rules of the American Arbitration Association shall apply unless inconsistent with the express provisions of the plan. The Suffolk County plan stipulates that Article 75 of the New York Civil Practice law and rules apply to the extent that they are not inconsistent with the Suffolk County plan.

When there are no stated rules of evidence, usually the hearing panel legal chairman has the power to rule on any objection that may fall under the rules of evidence. However, some of the plans, like the Colorado and Pima County plans, give power to the majority of the panel members when the joint chairmen cannot agree, or to overrule a single chairman.

Calling Witnesses

Like the Pima County plan, most of the screening panels permit any of the parties or the panel to call any witnesses. While the claimant does not have to present expert testimony, he may want to do so if it is available. However, usually he does not have an expert witness and it is for this reason that he is coming before the screening panel.

At least two plans explicitly limit the use of expert witnesses by the parties. Berks County limits it to one expert for each party. The New Mexico plan prohibits the parties from calling any expert witnesses. The Idaho plan apparently prohibits the parties from calling any witnesses by providing only that at the hearing ". . .the attorney submitting it for review shall be present and shall state his case." The Wisconsin plan permits only the introduction of written statements by witnesses. The Colorado plan stipulates that no expert witnesses may be called by the parties unless all parties consent in writing at least five days before the panel meets, or unless the panel itself calls the witnesses.

These prohibitions on a party presenting expertise in his behalf are somewhat puzzling, for it would seem that if a claimant has found a physician to testify on his behalf, the screening panel medical members would be receptive to scientific enlightenment by another medical opinion in the case. It is perhaps that in areas where there is a close-knit community of interest between physicians and lawyers, "outsiders" might sufficiently disrupt the status quo to cast doubt on the validity of the panel fairness per se. There is the danger, however, that the rights of a litigant may be prejudiced by this very attitude on the part of panels in excluding evidence on which the claimant honestly has relied in pursuing his claim.

In reviewing the records of panels where a claimant was permitted to bring his own expert witness and the attorney simply fulfilled his "ethical" obligation in carrying forth the agreement of the local medical society and bar association, it appeared that the presence of the claimant's expert witness, coupled with the crispness of advocacy demonstrated by counsel who was able to find the witness, had a salutory effect on finding for the claimant for such well-prepared claims. This is only a subjective impression, for the number of instances where claimants' attorneys vigorously pursued the case to the point of bringing an independent expert witness were few. This suggests that in those jurisdictions which widely employ medical-legal screening panels, there is at least the possibility that the plaintiff may suffer from a lack of total and thorough advocacy in his behalf.[44]

Transcript or Record of Proceedings

While the tendency of the screening panels to prohibit transcripts and records is related to their desire to limit publicity and encourage the informal cooperation of the doctors and lawyers involved, such secrecy tends, perhaps, to defeat the larger objective of improving the quality of medical care. Rather than require complete transcripts, which may stifle candor and add considerable expense to the proceedings, these alternative panels might encourage a brief summary of the factual basis of the case, the decision of the panel, and the reason for its decision, as a record for later appeal or other type of court litigation. Such an abbreviated record could also be used to facilitate the spread of useful information among the medical and legal professions concerning the evolving standards for medical care and note to all medical professionals in the jurisdictions the misadventure of a colleague causing injury to a member of the community, which (through the widespread knowledge of it) might not be repeated.

A statute has been passed and upheld in court in which the records of the Hawaiian plan are immune from subpoena. This decision would appear to stem from sound reasoning in that the Hawaii panel takes great care in circulating its findings for the express purpose of advising members of the medical community of specific malpractice incidents. These records and their beneficial purpose—increased quality of medical care—thus perhaps deserve immunity from uses which would restrict that benefit to society. Of further relevance to the practice in Hawaii is that the close association of the panel's activities with the process of peer review was remarkable and was observed in only this jurisdiction. The records of the Hawaii panel also include investigations made by it stemming from sources of complaint other than the injured patient. To allow access to such records would perhaps serve to stir up litigation.

With only one other exception, all the screening panels provide that there shall be no transcript of the proceedings and only a copy of the panel's decision shall be kept on file. The exception, the New Hampshire statutory screening panel, provides that there may be a transcript taken if a party desires it and is willing to pay for it. This transcript may be used in later proceedings.

Possible Findings and Their Effects

Types of Findings

Screening Panels

In practice, almost all of the screening panels make the same fundamental type of finding—whether the malpractice claim has some justification and should get medical expert testimony. However, the plans vary greatly in their particular definition of their finding. The language ranges from "substantial evidence of malpractice" and "reasonable medical probability that the claimant was injured thereby" (Pima County, for example), to "reasonable basis" (New Jersey) or "reasonable possibility that the acts complained of constitute professional negligence" (Idaho and Nevada, for example), or merely "merits support" (Philadelphia). The distinction of the Pima County plan—a two-fold test of breach of legal duty and causation—is an interesting one for it recognizes the elemental ingredients of the tort of negligence. From a review of records of the Pima County screening panel, however, this refinement appears unnecessary, for in only two cases was the claimant refused a finding on the basis of an absence of the element of causation. The inquiry, however, does serve to focus the deliberations of the screening panel within a more rigid framework of how issues of professional negligence ought to be properly analyzed.

Generally, screening panels do not make any finding as to damages. The New Hampshire statutory plan is the only exception to this rule; it explicitly makes a finding on the amount of damages to which the claimant is entitled. Under the New Hampshire plan, however, the finding of money damages is not binding on the parties. This facet of the plan is regarded as unique and valuable in that it gives the litigants a reasonable and informed "benchmark" around which to negotiate. Combining the informality of screening panels with the informed determination of money damages (as provided by arbitration), while preserving the nonbinding quality of the screening panels, would seem to afford the best of both procedures; and this new and innovative statutory scheme should be watched carefully.

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[44] The attorney representing a claimant in a jurisidction which has an active medical-legal screening panel might be influenced by Canons 7 and 8 to substantiate his ethical conduct in electing the panel route, not as enunciated locally, but by the American Bar Association's Canons of Professional Responsibility. Canon 7, "A Lawyer Should Represent a Client Zealously Within the Bounds of the Law," although forcefully drafted, could be interpreted as tempered somewhat in the medical malpractice claims arena by its Ethical Consideration 10, which provides: "...The duty of a lawyer to represent his client with zeal does not militate against his concurrent obligation to treat with consideration all persons involved in the legal process and to avoid the infliction of needless harm." Likewise, Canon 8, "A Lawyer Should Assist in Improving the Legal System," perhaps could be read as encouraging the formation of endeavors like medical-legal screening panels. Its Ethical Consideration 9 provides: "..The advancement of our legal system is of vital importance....lawyers should encourage, and should aid in making, needed changes and improvements." Neither EC 8-10 nor EC 8-9 has been construed, however. See, *Code of Professional Responsibility*, American Bar Association (Feb. 24, 1970).

Screening panel findings are generally the result of a majority vote of the panel members present throughout all of the hearings of a particular case. In addition, most of the screening plans permit dissenting members to indicate their dissatisfaction with the decision. A few of the plans, including the Franklin County plan, permit the chairman to break a tie vote. At least one plan (New Mexico) provides that a tie vote is equivalent to a finding of no negligence. The Milwaukee County and Hillsborough County plans explicitly stipulate that the panel may refuse to make a finding if they believe the issue of negligence depends on the credibility of testimony.

This expressed stipulation that a fact-finder must believe the testimony heard seems superfluous from the standpoint of rationality, for the credibility of written or oral statements is always in issue. If credibility of witnesses if of interest to screening panel rule drafters, it might be achieved by more extensive cross examination, provision for oath, and the making of a record; and the use of testimony for impeachment at subsequent judicial proceedings would be more likely to ensure that the screening panel is hearing the truth. However, if such a provision were drafted to allow independent medical judgment on the part of panel members, then it would seem to have a rational purpose. But the purpose of greater credibility could be served by more careful attention to providing expertise on the hearing panel.

Arbitration

The arbitration panels generally find both legal liability and the amount of damages to which the claimant is entitled. The Southern California Hospital plan explicitly provides that the damages and liability should be determined on the basis of comparative fault by a majority of the arbitrators. Arbitrators tend to allocate damages on the basis of comparative fault, whether or not the agreement so provides. The comparative fault provision deals with the multiple-defendant case and allocation or contribution among joint tortfeasors, and with the issue of whether the plaintiff minimized damages (not "comparative negligence"); however, the liability on award is joint and several irrespective of the arbitrator's schedule of contribution.

Effects of Findings on Parties, Counsel, and Insurers

Screening Panels

Most of the screening plans follow Pima County in defining the effects of the findings on the parties, their lawyers, and insurers. As noted earlier, most of them have required the parties to agree that the panel proceedings and decisions will remain confidential and may not be used in later court litigation. In addition, almost all of these plans promise the claimant that if the panel finds in his favor, the medical society will provide the names of experts who will cooperate (for a reasonable fee) in advising and testifying in his behalf. Although this promise is not phrased as legally binding, it is one ingredient which makes these agreements between the medical society and bar association continue.

While there is no binding effect in most of the screening plans on the parties, many of them follow Pima County in providing that if the panel finds against the claimant, the claimant's lawyer "shall refrain from filing any court action based on it unless personally satisfied that strong and overriding reasons compel such action. . . in the interest of his client and that it is not done to harrass or gain unfair advantage in negotiating for settlement.''[45]

There are only four significant deviations from this largely unbinding effect. The Hillsborough County (Florida) plan provides that a claimant must tell any new lawyer of the panel proceedings and its decision or he must waive his right to secrecy of the earlier panel proceedings. Both parties and their attorneys must pledge a good-faith effort to settle within 30 days after the panel decision, including making an offer for settlement.

Under the New Hampshire statutory plan, there is no binding effect if either party rejects the panel's decision; but the decision is legally binding if both parties accept it.

In order for the claimant to obtain expert testimony under the New Jersey plan, he must agree before the proceedings to be bound by any adverse decision. If he does agree and the panel rules in his favor, the medical society is legally bound to provide three names of expert witnesses. In *Marcello* v. *Barnett*,[46] the court upheld the right to agree to this binding effect, but also to withdraw from it prior to panel proceedings. If the claimant does not agree to be bound, his attorney cannot continue the case if the panel rules against the claimant, although the claimant may retain a new lawyer.

Under the Franklin County plan, a claimant must discontinue his suit or is prohibited from filing it in court if the panel finds against him. Companion claimants are also bound by an adverse ruling, as they had agreed to be bound prior to the panel proceeding. If the panel finds for the claimant, it merely recommends that the claim be settled; if it is not settled, the Columbus County Academy of Medicine promises to provide two names of expert witnesses who will be willing to testify in his behalf for a reasonable fee. However, there is no binding effect at all on the insurers or the lawyers.

Arbitration

The binding nature of arbitration is the factor that distinguishes it from screening panels. In most jurisdictions, decisions are generally binding and enforceable upon docketing and entry. In fact, they are usually filed with the court for entry of judgment. If the judgment is not voluntarily paid, the party may proceed with execution and levy as on judgments at law. In addition, the arbitration decision may be binding on the insurer who has been joined in the proceeding, but he may disclaim liability if he has not been properly joined or has not consented to the arbitration proceeding.

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[45] For a strong view *contra*, see, King, "Suits Against Physicians for Professional Negligence from the Defendants' Point of View", *Md. State Med. J.* 301 (1970), p. 84 which suggests the quoted ". . .offer by the plaintiffs' bar is hollow. . ."

[46] 236 A.2d 869 (New Jersey, 1967).

Rehearing Availability

Screening Panels

Most of the screening panels are silent on rehearing availability. Those like Pima County which have no specific provision for rehearing availability have occasionally encountered the problem. Generally in a case wherein the breach of legal duty was found by the panel but the element of causation absent (since the element of causation due to the unique facts of the case did not really require expert proof to sustain it), it is questionable whether or not rehearing should have been granted. Several motions were filed and, in an extra-judicial atmosphere, rather authoritatively and expertly handled.

One of the problems of these organizations is that they do not rule on questions of operating procedure and create a body of case law about their written rules. The panels are employed so infrequently that the establishment of a case and decision reporting system is a luxury that few could afford. All such panels could benefit by referring questions of law and procedure to the attorney members, or perhaps a super-ordinate body within the bar association for opinion and decision. These records could then be filed with the rules of the plan, and at particular periods the rules which had been modified by interpretation could be modified for adoption by the medical society and bar association.

The Montana plan explicitly provides for a rehearing by another hearing board if there is a tie vote. The New Jersey plan may grant a single rehearing under the same conditions as the initial hearing, including the same counsel for both claimant and defendant, if three members vote for rehearing.

Arbitration

There are limited grounds for review of arbitration awards. These are discussed extensively on a state-by-state basis in "Alternatives to Litigation IV: The Law of Arbitration in the United States."

Evaluation

Source of Medical-Legal Agreements

A feature of many of these plans which bears on their evaluation is not found in their published rules. It is noteworthy that the rules of the majority of medical-legal screening panels were embodied within broader agreements between local medical societies and bar associations, in which elaborate rules of conduct and behavior between the two professions were sought to be regulated and their competing interests reconciled.

When viewed in the broader context of how agreements are made to submit medical malpractice claims to informal screening procedures, it appears that the motivations of both professions are not entirely altruistic. Through these many agreements, lawyers gain the needed cooperation from physicians in pursuing their economic endeavors in litigating personal injury claims. The physicians, reluctant to be called from their busy practices, have apparently included in the agreements provisions through which they are assured of courtroom scheduling, dignified questioning and cross examination while testifying, and payment of expert fees. And from it all stems their more cooperative response to the needs of lawyers.

Whether these all-embracing interprofessional agreements are in the best interest of society and whether, in fact, provisions which purport to place upon an attorney an ethical obligation to submit a claim in behalf of his client to this secretive informal claims-deciding group, or to pursue with the vigor of advocacy which is the hallmark of the legal profession, is a question which cannot be resolved by any study, however thorough and complete. It is true that attorneys need physicians and apparently are willing to tread close to compromising the rights of a small class of tort claimants in order to secure their help. On the other hand, just as the physicians are the captives and captors of the professional liability insurance industry, so are they entwined with the legal profession in these multi-faceted interprofessional agreements.

All of this leads to the central inquiry of what this means to members of society who do not share the exclusive privileges afforded to both of these professions. Here, too, the main contribution of this report can only be the issues which raises.

Effect on the Quality of Medical Care Delivery

As this study progressed, it became apparent that little, if any, information gained by screening panels was used to improve the quality of medical services by preventing situations which produce injuries. In most other fields, it is axiomatic that one "profits by his mistakes" by applying the knowledge from these mistakes, how they occurred, or what failed, to devising changes in the system which failed. The feedback of this knowledge often provides the vital information for proper change. This has not been the case with medical malpractice.

This positive use of medical malpractice information to improve medical care was found in only one of the medical malpractice screening panels—that sponsored by the Honolulu County Medical Society. It became of special interest to this study because of its organized use of information to enhance the quality of medical care, as well as other unique features.

The factors which tend to make all of the other panels apparently ignore the opportunity to make better use of their findings should be recognized. First, medical malpractice is such a negative topic to physicians that they tend to disregard and avoid all association with it. Several medical organizations have apparently gone to great trouble to adopt synonyms for the very term "malpractice" and to inculcate their administrative and professional staffs with these more pleasant names for an unpleasant problem. Second, by its very nature, the medical-legal community which typically forms a screening panel does not deal with cases in the aggregate and lacks the perspective to look back upon its cases with the desire to find common factors which could provide guidance to the medical community. This second point is apparent from the malpractice literature, the vast majority of which deals with individual cases in narrative fashion and seldom as groupings or classifications of cases as is provided by the classifications developed by this study. Only one article,[47] written about a decade ago, provided any guidance in the development of the syndromes, and thus no quantitative trend analysis of malpractice syndromes was possible. Although many insurance carriers and hospitals have elaborate computerized systems for the recording of "incidents," there was little apparent follow-through in their use as seen by this limited study.

The Honolulu panel differs in several ways from the others studied. These differences explain the reason for the high interest in the quality of medical care exercised by the Medical Practices Committee, as it is known. That committee was a subcommittee (a restructuring is underway) of the Peer Review Committee. The task of reviewing malpractice claims is a relatively recent addition to its previous responsibilities, which dealt mainly with fee disputes. By contrast, most other panels were formed at a time when the rate of medical malpractice claims was rapidly increasing and many insurance companies withdrew from the field.

Peer review in Hawaii has always been self-motivating. This is contrary to panels found in other states, in which the mechanism to initiate peer review was observed to be some external stimulus, such as a request from health-care plans to investigate fee abuses or prescription practices, or charges brought by government bureaus for over-prescription of narcotics or controlled substances. These are only two of the many sources which can and do initiate peer review under the Honolulu plan. In addition, the request for peer review can originate with its own members, or from a physician's request without claimant knowledge, or by the claimant himself. It is this background or peer review, its responsiveness to all parties, and its responsibility to the medical community which has caused the Medical Practices Committee's emphasis on the quality of medical care, with liability for a claim an important but almost secondary factor.

The responsibility to the public is preserved by designating a member of the clergy to be the committee's nonlegal/medical member. Monsignor Kekumano, who has filled the position for 15 years, has brought the committee into a more harmonious relationship with those who appear before it. The Monsignor is highly regarded in the Hawaiian community; his presence is considered to raise the stature of the committee. Due to his long term of service, he has provided a continuity to the committee which otherwise might not have been present. He has also appeared on a local television program sponsored by the medical association to discuss the Medical Practices Committee and medical malpractice, indicating not only the respect of the medical community but its willingness to present the topic of malpractice publicly and candidly.

The questions comprising the determination of medical malpractice are both medically and legally complex. It is difficult for a lay member to comprehend those elements and place this determination above compassion. In discussions with the Monsignor, it became apparent that he possessed the intelligence, sensitivity, and ability necessary to remain remote from individual personalities—traits which must reside in any panel member. In fact, a person less than this could be detrimental to the committee's ability to function.

A lawyer is also on the committee, but his role is that of an advisor on the law and he does not represent the medical society.

The Medical Practices Committee also handles and schedules cases differently than other panels studied. Incidents brought to its attention are first turned over to a committee member for investigation. This member reports his findings; and in the course of subsequest weekly meetings, the defendant, claimant, and any expert witnesses which the committee desires may appear. There is never a confrontation between plaintiff and defendant.

While being as fair and unbiased as possible, the committee's primary responsibility is to the medical community. Findings are first given to the defendant for his action. If the plaintiff has requested the committee action, he is informed of the committee's findings only after the defendant has been given the opportunity to settle the case if the committee has found him negligent. This procedure was developed to prevent action of the committee from resulting in higher plaintiff demands.

If the defendant does not abide by the committee decision, sanctions against him are possible. The most powerful sanction, and the one which results most directly in improved medical care, is derived from another of the peer review committee's functions—insurance coverage review. This committee, the Professional Liability Committee, operates at the state level. If a physician desires medical malpractice insurance coverage through the medical society carrier (which at times was the only available source), he must be a member of the society and his coverage must meet with the Professional Liability Committee's approval. This coverage may be reviewed at any time and thus can be reduced or limited in light of findings based on investigations concerning alleged malpractice. For instance, a physician may have insurance coverage withdrawn for practices in which the committee feels he lacks competence (e.g., radiology, certain surgical procedures). In this way, a physician's practice is modified to prevent recurrent negligent actions. No other resolution mechanism, including the action at law, has such a direct and far-reaching provision.

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[47] D. Mills, "Medical Lessons From Malpractice Cases," *J.A.M.A.* 183 (March 1963). 18 Mention should also be made of S. Schindell, Epidemiology of Professional Liability Losses," 190 *J.A.M.A.* 84 (Nov. 1964), but its usefulness to the practitioner is limited.

The last means of affecting the quality of medical care is through the medical society's sanction of suspending or cancelling membership. Such an action is made known to the membership, who then withdraw their support in the way of referrals.

A more general feedback to the medical community is the required annual report, both written and verbal, given to the membership at its annual meeting, at which the chairman summarizes the types of cases heard.

While the power of the committee and medical society appears awesome, there is no evidence of its abuse; and the ability of these bodies to positively affect the quality of medical care by proper use of this power might be recognized as a prototype by other societies who seek to provide professional regulation from within the profession.

Section IV
Conclusions

A. INTRODUCTION

This report concludes with the observation that the probability of achieving the objectives of alternatives to litigation by the medical community and the professional liability insurance industry (consistent with the interests of the public) could be enhanced by emphasizing more widespread establishment of voluntary medical-screening panels and encouraging legislation which would overcome their inherent limitations. Finally, to the extent possible, achievement of this objective should enhance the quality of medical-care delivery, finding alternatives to injury as well as alternatives to litigation.

This section summarizes and comments on the more important findings discussed throughout this report.

B. SPECIFIC CONCLUSIONS

Kinds of Claims Heard

There are major differences in the kinds of claims heard by screening panels, depending on their professional constituency. It is concluded that screening panels generally hear claims remarkably similar in their characteristics to those claims involved in actions at law. Physician screening panels, however, based on the quantitative investigation, tend to hear a higher proportion of the more severe claims occurring in their jurisdiction.

All of the alternative plans to litigation heard and decided cases involving the failure-to-diagnose versus improper-treatment origin of the claim in about the same relative proportion as each other and the action at law, with the exception of the Pima County medical-legal screening panel. This plan considered a far higher proportion of failure-to-diagnose claims than any other type of plan studied, which lends some credibility to the contention of screening panel critics that panels increase the number of claims. This criticism is offset, however, by noting that although a higher proportion of claims alleging diagnostic error was heard by this medical-legal screening panel, they were dealt with more favorably to the physician than any other class of cases heard. On this basis, it is concluded that the criticism of screening panels—that they tend to increase the number of claims—is unwarranted.

Quantitative Impact on Lawsuits and Trials

Medical-legal screening panels appear to provide a forum where a grievance may be aired without imposing upon the physician-defendant the significant embarrassment inherent in an action at law. A significant proportion, about 24.5%, of these claims is aired and disposed of without the filing of an action at law. Almost half of all claims in a jurisdiction which had a medical-legal panel were formally initiated by panel filing rather than by lawsuits. Thus, the opportunity for settlement by the panel was twice as great as that actually achieved.

Court-sponsored screening panels are not as effective as the medical-legal plans. Only about 6% of the lawsuits were settled by the only such panel having an extensive operating experience, and the panel had only a negligible effect on reducing the number of lawsuits filed. An experimental court-sponsored screening panel reduced the backlog of cases filed by almost one-fourth of those which it considered, but its effectiveness has yet to stand the test of time.

Fairness of the Procedures

In general, screening panels find for the claimant (or against the physician) with about the same frequency as do actions at law. To the extent that this similarity of behavior with the action at law represents fairness, it is concluded that the medical-legal screening panels, court-sponsored screening panels, and physician-and-advisory screening panels are as fair to the litigants—claimant and physician—as the action at law. This conclusion, however, does not apply to physician screening panels, which exhibit a far greater tendency to find in favor of the physician. To this extent, physician screening panels do not exhibit the same degree of fairness to the claimant as do the other alternatives to litigation.

It is unfortunate that not enough quantitative information exists to study the inherent decision-making fairness of arbitral proceedings to conclusively determine whether the procedure will be about as fair as the other plans.

Speed in Resolving Claims

Although there are few cases reported, there is apparently no significant advantage to arbitration over the action at law in speedily resolving medical malpractice claims and its potential for doing so appears limited. By contrast, screening panels of whatever variety do provide a somewhat more timely claims threshold determination which frequently results in more speedy resolution of the claim.

There are methods of speedily resolving claims which are inherent in the judicial process itself and which do not depend on formal alternatives to litigation. It is concluded that the summary judgment procedure has been widely underemphasized as an important factor in resolving medical malpractice disputes.

Cost of Proceedings

To the extent that alternatives to litigation are coupled with the judicial mechanism or, like the judicial mechanism, attempt to resolve claims with finality, their costs of operation to the litigants approach those of an action at law. These attributes of court-sponsored screening panels and arbitration—that they embrace most or some of the judicial machinery—are major cost contributing factors. The physician screening panel is the least expensive to operate, but it does not provide a hearing for the claimant. Although much of the time for the operation of medical-legal screening panels is donated by the physician and attorney participants and is therefore not borne by the litigants, this imputed cost must be recognized as a price paid by society in resolving claims by this process.

Motivations of Persons Affected

Physician Screening Panels

The inherent motivation behind physician screening panels is to protect the physician. To this extent, this report offers no conclusion as to the fairness of physicians in conducting proceedings which are important collectively to the medical community from the standpoint of their professional reputation and cost of liability insurance. However, to the extent that physician screening panels are used as a marketing device by the liability insurer to ensure continuity of operation in the face of rising premiums, rather than a good faith endeavor to reach settlement in meritorious cases, then it is concluded that such plans are unfair to both physicians and claimants and their use should be discouraged.

Medical-Legal Screening Panels

The genesis of many medical-legal screening panels probably stems from the need by lawyers for more widespread cooperation from the medical community in their proof of other personal injury claims, as well as the desire by physicians to insulate themselves from medical malpractice claims. It is concluded that the totality of motivation by both professions in establishing these medical-legal panels is not entirely altruistic.

There are also dangers to the consumer and public at large in allowing close knit groups of attorneys and physicians to determine the merits of claims without a full and forceful adversary proceeding. Subjective impressions have been recorded of at least instances of a lack of full and thorough advocacy on the part of attorneys bringing claims to medical-legal screening panels, especially where the medical society has provided the expert to assist the claimant's attorney in preparing for the panel hearing. This danger, however—real or imagined—also exists (and was observed) in the prosecution of actions at law. But this must be weighed against the good faith exhibited by physicians in cooperating with the public in the hearing and resolution of medical malpractice claims and against the low cost of doing so. It is in this regard that the benefits to society afforded by an inexpensive, optional, threshold forum are concluded to outweigh any real or imagined adverse attributes of such a proceeding.

Court-Sponsored Screening Panels

Screening panels operated within the judicial framework appear attractive to jurisdictions whose congested dockets are such that justice is thereby denied to all classes of civil litigants. To the extent that complex and lengthy trials can be eliminated from these dockets, the judicial process is enhanced for all who use it. Whether medical malpractice cases ought to be given preferential treatment by the courts is a decision for each jurisdiction, for if the criterion for such special treatment is estimated trial duration and complexity, then mediation attempts should be made impartially in all such cases. There is little apparent justification for the judicial process to give one segment of tort claimant a speedier remedy than another, simply based on the factual origin of his injuries, for highly complex and disputed medical testimony and liability fact situations abound in many other personal injury cases. Further, other studies have shown that the impact on the judicial system of medical malpractice litigation is slight to insignificant. Finally, there already exist within the rules of civil procedure of the vast majority of jurisdictions a host of procedures for the summary disposition or simplification of claims, which raises the question of whether the benefits gained by these plans are worth their cost in time expended and impartiality of the courts.

Arbitration

To the extent that arbitration achieves public acceptance and provides the advantages which are attributed to it of a speedy and inexpensive claims resolution medium, its use must be encouraged. However, it is apparent from the literature that the major motivation behind establishing arbitration plans is to benefit hospitals, physicians, and, principally, the insurance industry, by privacy of proceedings and protection from large sympathy verdicts of juries for which safeguards already exist in the judicial process. It is also clear that its stated advantages of speed and economy apply only to the hearing phase. Arbitration neither reduces the overall time required for claim resolution nor economizes greatly the preparation phase of the medical malpractice claim.

Limitations on the Effectiveness of Alternatives to Litigation

It is a conclusion of this report that the major inherent limitation to widespread use of screening panels is their limited jurisdictional scope. Frequently, jurisdiction over parties and subject matter is self-imposed, limited only to members of the local medical society. The inability of the screening panel to hear and decide claims in which physicians are charged along with an institution (over which the screening panel has no jurisdiction) is judged the single most important limitation. The effectiveness of one plan studied could be doubled if its jurisdiction were enlarged—reducing the number of lawsuits by about 50%. It is concluded that statutory recognition must be given to screening panels if their jurisdictional scope is to be enlarged. At the time that statutory recognition is given for the purpose of gaining more widespread jurisdiction over parties, the question of whether filing a claim with the screening panel constitutes bringing a claim within the statutory period for limitation of actions should also be resolved. In this regard, the New Hampshire professional liability statutory plan serves as a useful model to other jurisdictions.

The second most significant limitation of screening panels is that while the parties are advised about liability, no opinion or expert guidance as to damages is given to them. This problem has also been solved by the procedure implemented statutorily in New Hampshire, which gives a benchmark around which to negotiate.

Arbitration is a device whose use in resolving medical malpractice disputes could easily be frustrated by decisions of the courts or by consumers of the medical-care delivery system unless it is imposed upon them. It is clear from the overwhelming "acceptance" of the arbitral provisions embodied in the current treatment agreements that the public has not yet discovered what the fine print means. To the extent that arbitration is consensual through the formation of a contract freely arrived at with a patient who understands the basis of the bargain, it promises a socially acceptable method in achieving a widespread reduction in the frequency of litigated claims. If, however, arbitration should achieve the public image of an inherently unfair device imposed by the medical community for its own economic interest, then the public will simply take care to avoid the arbitral provision at the time they contract for medical care and services.

The final important limitation of all alternatives to litigation, and most particularly screening panels, is that they do not benefit by the experience of other such plans. Spokesmen for many of the screening panels believed that their plan was the only one of its kind. The growing number of screening panels and endeavors by interested members of the medical community and legal profession to establish these plans in their jurisdictions suggests the need for a national clearinghouse for the exchange of information to allow their informed evolution as a settlement device.

Effect on the Quality of Medical-Care Delivery

It is unfortunate that only one of the many plans for the alternative resolution of medical malpractice claims made use of its experience or findings in an organized way as a quality control mechanism. It is concluded that the action at law, which only clumsily informs the medical community of its legal duty as to standards of quality in rendering care and treatment, although far from ideal, is more effective than all but one of the alternatives to litigation studied. In addition, no plan studied kept more than rudimentary records of operations or had undertaken more than cursory self-evaluation of its effectiveness.

Estimated Potential of Alternatives to Litigation

Only a small fraction of medical malpractice claims is submitted to alternative forums for their resolution. There is great potential for their more widespread use if information about them is disseminated in a form which would permit their informed establishment and operation. It is estimated that if the jurisdictional and statute-of-limitations problems associated with medical-legal screening panels were removed, the initiation of claims by the filing of lawsuits against physicians and other members of the medical community could be reduced by as much as 75%. The number of cases actually leading to the litigation process after the threshold determination could probably be reduced by as much as 50%.

Section V

Recommendations for Future Research

A. QUANTITATIVE ANALYSIS OF ALTERNATIVES TO LITIGATION

This section briefly describes what appear to be potentially the more productive near-term research areas from the standpoint of supplementing this study of alternatives to litigation. Specifically, a number of promising methods of resolving medical malpractice claims were not analyzed quantitatively in this study because sufficient data was either not available from the operation of the claims resolution forum, or access to the data came too late in the study. It is recommended that the following plans be evaluated in depth:

Suffolk County (New York) Screening and Arbitration Plan

This novel medical-legal screening panel has been granted limited arbitration jurisdiction through the cooperation of the liability insurance carrier. It represents an interesting combination of the facets of the medical-legal screening panel and arbitration. A quantitative analysis of the plan is needed to provide an evaluation of its effectiveness.

New Hampshire Professional Liability Statutory Plan

This dispute resolution forum also combines the attributes of the screening panel and arbitration, but only on an elective basis. The plan is embodied within the framework of the courts for its administration. A quantitative study of its operation would permit an evaluation of its effectiveness compared to the Suffolk County plan, as well as the other plans discussed in this report.

Casualty Indemnity Exchange Arbitration Plan

Further study of this plan's effectiveness should be undertaken when the company has accumulated a statistically significant number of cases for comparing claims incidence and resolution effects brought about by the physician-patient arbitration arrangement.

Hawaii Medical Association

The records of cases from this unique physician-and-advisory screening panel (which operates within the peer review structure of the medical society and was the only plan to actively use its findings in an endeavor to enhance the quality of medical care) became available too late for analysis in this current study. Detailed quantitative analysis of this screening panel should provide the basis for determining whether the institutional characteristics of the plan could be adapted to other plans—to give physicians an alternative to the more self-serving physician screening plan and the medical-legal screening panel.

Hospital Arbitration Plans

Presumably the Southern California Hospital plan and the Southern California Kaiser arbitration plan will provide data from a significant number of arbitration hearings in the not too distant future. Since this study necessarily left unanswered many important questions about the application of arbitration to the resolution of medical malpractice claims, a quantitative analysis of the operation of these plans should be undertaken when sufficient data become available.

B. RELATED NEAR-TERM RESEARCH

The following two areas of research are recommended for a better understanding of attitudes of the physician, the insurance industry, and the general public on the handling of malpractice claims:

Insurance Industry and Physician Attitude Survey Regarding Alternatives to Litigation

The current study determined that a number of professional liability insurance companies support or condemn the use of screening panels. Other insurance companies support only particular kinds of screening panels. It is recommended that a study be undertaken to discover the attitudes underlying the policy reasons for this behavior by the insurance industry.

Comparison of Medical Malpractice Claims Handling With Other Personal Injury Claims

A number of analytical techniques developed in this study have proved useful in examining the way in which claims are handled. In particular, the use of the decision ratio, severity index, and injury classification techniques provides a multi-dimensional basis for case-handling comparison. It is recommended that a study be initiated to determine the extent to which medical malpractice claims differ in their resolution from other personal injury claims, using these analytical techniques. A number of hypotheses should be evaluated in the study. For example, it is recognized that jurors are aware that automobile drivers carry liability insurance. It is less clear that the public is as knowledgeable about professional liability insurance. The inquiry would therefore focus on the attitude of jurors in both cases situations.

In addition to the attitudinal aspects of damage awards, the litigated body of cases analyzed from the standpoint of their expected economic value provides a good basis of comparison if a like body of information were analyzed in other personal injury situations. In addition, there are a number of injuries for which direct statistical comparisons could be made to determine whether and to what extent awards or settlement practices differ.

C. LONG-TERM RESEARCH FOR ENHANCEMENT OF SCREENING PANEL IMPLEMENTATION AND OPERATION

One conclusion of this study was that the various alternative plans were evolving in an uncontrolled fashion, making little use of the experience of other plans. The following two research areas would ensure a desirable degree of uniformity in future plans. The tasks are described as "long-term" because of the time required to perform the necessary study and verification trials.

Information Exchange Among Alternatives to Litigation

It is recommended that a study be undertaken for the development of a national clearinghouse for the exchange of information among the various plans. Purpose of the clearinghouse would be to collect and disseminate experience data for the benefit of jurisdictions which in the future propose to adopt some form of screening panel, as well as to enhance operational effectiveness of existing plans.

APPENDIX A

COMPUTER CODE DEFINITIONS

The information defined by these codes appears only on the first card. The second card contains only entry identification, dates, and dollar amounts.

PLAN & FORUM (Column 5)

1	Pima County
2	District of Columbia
3	New Jersey
4	New Mexico
5	Jury Verdict Research
6	Maricopa County
7	Maryland
8	Ross Loos

PLAN & FORUM (Column 6)

0	Screening Panel Only
1	Action at Law Only
2	Screening Panel and Action at Law
5	Arbitration

NUMBER OF DEFENDANTS (Column 7)

0	Unknown
1	One
2	Two
3	Three
4	Four
5	Five
6	Six
7	Seven
8	Eight
9	Nine or More

CHARACTERISTIC OF Δ

(Columns 8-9 Δ #1, Columns 16-17 Δ #2)

1. PHYSICIAN—NON-SURGICAL

1 GP
2 Internist
3 Pediatrician
4 Allergist
5 Pathologist
6 Resident
7 Dermatologist
8 Radiologist
9 Psychiatrist
0 Unknown/Other

2. SURGEON

1 General
2 Neuro
3 Orthopedic
4 Plastic
5 Ob-Gyn
6 Anesthesiologist
7 Urologist
8 Otolaryngologist
9 Ophthalmologist
0 Unknown/Other

3. HOSPITAL

1 University
2 County/Public/Municipal
3 Church
4 Private
5 Osteopathic
6 Institution for rehabilitation/convalescent
7 blank
8 blank
9 blank
0 Unknown

4. OSTEOPATHS

1 Physician
2 Surgeon
0 Unknown/Other

5. MEDICAL SERVICES

1 Transfusion related
2 blank
3 Laboratory medicine
4 Physical therapist
5 Ambulance Co.
6 blank
7 blank
8 blank
9 blank
0 Unknown

6. MEDICAL SUPPLIES

1 Surgical
2 Diagnostic
3 Intravenous catheter
4 Wholesaler
5 Pharmacy
6 Diathermy machine
7 blank
8 blank
9 blank
0 Unknown

7. MANUFACTURER

1 Drug company
2 Heart Pacemaker
3 blank
4 blank
5 blank
6 blank
7 blank
8 blank
9 blank
0 Unknown

8. EMPLOYEE

1 Nurse
2 Technician
3 Intern
4 Orderly
5 blank
6 blank
7 blank
8 blank
9 blank
0 Unknown

9. OTHER

1 Medical Group
2 Optician
3 Podiatrist
4 School (non-medical)
5 blank
6 blank
7 blank
8 blank
9 blank
0 Unknown

0 UNKNOWN

SYNDROME

(Columns 10-12 Δ #1, Columns 18-20 Δ #2)

1. **FAILURE TO DIAGNOSE**

00	Unknown
01	Infection
02	Fracture or Dislocation
03	Cancer
04	Diabetes
05	Intrauterine Pregnancy
06	Tubal Pregnancy
07	Endometriosis
08	Normal Pregnancy
09	Other Pregnancy and Related Problems
10	Hemorrhage
11	Thrombosis
12	Ulcer or Ulcer Complications
13	Appendicitis
14	Large Bowel Lesion
15	Tendon Laceration
16	Severed Nerve
17	Retained Placental Fragments
18	Poisoning
19	Due to Tardiness of Attendance
20	Implanted Foreign Body
21	Arthritis
22	Pneumothorax
23	Myocardial Infarction
24	Polyneuritis
25	Mental Problem
26	Gallstones or Gall Bladder Disorder
27	Kidney Disorder
28	Eye Disorder
29	Good Health
30	Drug Addiction, Dependency, or Intoxication
31	Gastrointestinal Disorder, other than ulcer
32	Tumor, Non-malignant
33	Gangrene
34	Liver Disorder
35	Hernia
36	Allergy

2. **IMPROPER TREATMENT**

00	Unknown
01	Drug Overdose
02	Drug Side Effect
03	Drug Addiction
04	Surgical, Material Left
05	Surgical, Operative
06	Surgical, Post-operative
07	Surgical, Delay
08	Medical device, prosthesis
09	Medical equipment
10	Infection
11	Insufficient therapy
12	Fracture or dislocation
13	Failure to use restraints
14	Error in writing of prescriptions
15	During examination
16	Lack of supervision or control

3. **ANESTHESIA**

00	Unknown
01	Explosion
02	Cardiac arrest
03	Catastrophy of undescribed cause
04	Adverse reaction

4. **TRANSFUSION**

00	Unknown
01	Mismatch
02	Infection

5. **INJECTION SITE INJURY**

00	Unknown
01	Ulnar or radial nerve
02	Sciatic nerve
03	Occipital nerve
04	Tissue
05	Artery, vein
06	Spinal, paralysis
07	Bone puncture
08	Infection
09	Other

6. **ABANDONMENT**

SYNDROME

7. AVAILABLE FOR LATER USE

8. NOTEWORTHY LEGAL THEORY

00	Unknown
01	Contract
02	Warranty
03	Seduction
04	Battery, Informed consent
05	Agency
06	Product liability

9. GROSS PATIENT MISUNDERSTANDING

00	Unknown
01	Surgery for asthma
02	Diabetes from allergy treatment

0. UNKNOWN

SCREENING PANEL DISPOSITION

(Column 13 – Defendant No. 1
Column 21 – Defendant No. 2)

0	Unknown
1	Forum Improper, not heard
2	Yes, Yes
3	No, No
4	Yes, No
5	No consent by defendant to appear
6	Withdrawn by plaintiff, filed action at law, dissatisfied
7	Withdrawn by plaintiff, result of discovery
8	Withdrawn by plaintiff, reason unknown
9	Withdrawn by plaintiff, through agreement, settlement

ACTION AT LAW DISPOSITION

(Columns 14-15, Defendant No. 1
Columns 22-23, Defendant No. 2)

00	Unknown
13	Mistrial
14	Dismissed with prejudice, withdrawn by plaintiff through agreement with defendant
17	Withdrawn by plaintiff, reason unknown
18	Dismissed without prejudice
19	Pending
20	Verdict for plaintiff
30	Verdict for defendant
50	Summary judgment for plaintiff
60	Summary judgment for defendant
70	Judgment N.O.V. for plaintiff
80	Judgment N.O.V. for defendant
90	Forum improper, not heard

INJURY (Used only with JVR data)

(Columns 24-26)

000	**UNKNOWN**
100	**BACK**
110	Cervical Strain (CS)
111	Cervical Strain and Shoulder Strain
112	CS and Concusion
115	Aggravation of CS
118	CS and Lumbar Strain (LS)
120	LS
125	Aggravation of LS
130	Back Strain (unspecified)
135	Aggravation of Back Strain
136	Lordotic Curve
140	Vertebral Fracture
141	Vertebral Subluxation or dislocation
145	Vertebral Aggravation
150	Disc Damage
155	Aggravation of Disc Injury
165	Aggravation of Congenital Conditions other than Spondylobisthesis
175	Aggravation of Congenital Conditions (spondylobisthesis spondylosis kyphosis)
180	Coccyx Fracture
181	Coccyx and Sacrum Bruise, Cont and Sp.
182	Sacrum Fracture
185	Aggravation of Sacrum and Coccyx Injury
190	Spinal Injury – Permanent Paralysis
191	Spinal Injury – Temporary Paralysis
195	Aggravation of Spinal Injury
200	**HEAD**
211	Concussion
212	Concussion with Syndrome
213	Concussion with minor injury
221	Skull fracture
231	Brain Damage – Severe
232	Brain Damage – Minor
235	Brain Damage Aggravation
241	Facial Lacerations
242	Head Lacerations
243	Scalp Burns – Hair Loss
251	Facial Scarring – Female, Minor
252	Facial Scarring – Female, Adult
253	Facial Scarring – Male, Minor
254	Facial Scarring – Male, Adult
256	Facial Nerve Damage
257	Facial Burns
261	Jaw Fracture
262	Nose Fracture
263	Facial Fracture other than Jaw and Nose
271	Nose Injury – Non-fracture
281	Eye Injury – No vision loss (1 eye)
282	Eye Injury – Minor vision loss (1 eye)
283	Eye Injury – Serious vision loss (1 eye)
284	Eye Injury – Total vision loss (1 eye)
286	Eye Injury – Total vision loss (both eyes)
287	Eye Injury – Minor vision loss (both eyes)
288	Eye Injury – Serious vision loss (both eyes)
291	Teeth Injury
292	Other Mouth Injury
293	Ear – Laceration
294	Ear – Loss of hearing
296	Throat Injury – No voice damage
297	Throat Injury – Minor voice damage
298	Throat Injury – Serious voice damage

INJURY (continued)

300	**ARM AND CHEST**
311	Wrist Fracture
312	Wrist Sprain, Laceration, and Cont.
321	Finger Amputation — 1 finger
322	Finger Amputation — 2-5 fingers (1 hand)
323	Finger Amputation — on both hands
324	Finger Fractures
326	Finger Contusions, Laceration, and Sprain
331	Hand Fractures
332	Hand Burns, Contusions, Lacerations
333	Hand or Forearm Amputation
330	Hand Injury — other
341	Forearm Fracture
342	Forearm Burns, Contusions, and Lacerations
340	Forearm Injury — other
351	Elbow Fractures
352	Elbow Inflammations
353	Elbow Ulnar Nerve Damage
360	Shoulder Injury — other
361	Shoulder Contusion, Bruise, and Lacerations
362	Shoulder Sprains and Strains
363	Shoulder Fracture
364	Shoulder Dislocation
360	Shoulder — type unknown
366	Shoulder Bursitis (Traumatic)
370	Chest Injury — other
371	Chest Bruises, Cont. and Lacer. Chest Cartilege
372	Chest Rib Bruises and Contusions
373	Chest Rib Fractures
374	Chest Sternum Fracture
376	Chest Sternum and Ribs Fractured
377	Chest Lung Damage
378	Chest Heart Damage
381	Abdomen Injury — External
383	Abdomen Injury — Internal

400	**LEG**
410	Knee — unknown
411	Knee — bruises, contusions, lacerations
412	Knee Sprain or Strain
413	Knee Cartilege
414	Knee Patellar Bursitis
416	Knee (Patella) Fracture
421	Femur (Thigh) Fracture
422	Femur (Thigh) Bruise, Contusion
425	Femur — aggravation
431	Pelvic Fracture
441	Ankle Sprain
442	Ankle Fracture
443	Ankle Abrasion, Laceration, Contusion
451	Foot Fracture
452	Toe Fracture
453	Toe Amputation
454	Heel Fracture
455	Foot Amputation (whole or part)
456	Miscellaneous Foot Injuries
461	Leg Fracture (Tibia or Fibula)
462	Leg Fracture (Tibia and Fibula)
465	Aggravated Leg Fracture
471	Leg Amputation — 1 leg
472	Leg Amputation — both legs
480	Leg — other
481	Leg Burns
482	Leg Laceration, Contusion, Abrasion
483	Leg Vascular Damage (Phlebitis)
485	Leg Aggravation
486	Leg Paralysis — not sciatic

INJURY (continued)

500	**DEATH – ADULTS**
510	Male, Single – age unknown
512	Male, Single – 21-29
513	Male, Single – 30-39
514	Male, Single – 40-49
515	Male, Single – 50-59
516	Male, Single – 60-65
517	Male, Single – over 65
520	Male, Married – age unknown, no children
522	Male, Married (no children) – 21-29
523	Male, Married (no children) – 30-39
524	Male, Married (no children) – 40-49
525	Male, Married (no children) – 50-59
526	Male, Married (no children) – 60-65
527	Male, Married (no children) – over 65
530	Male, Married (dependent children) – age unknown
532	Male, Married (dependent children) – 21-29
533	Male, Married (dependent children) – 30-39
534	Male, Married (dependent children) – 40-49
535	Male, Married (dependent children) – 50-59
536	Male, Married (dependent children) – 60-65
537	Male, Married (dependent children) – over 65
542	Female, Single, 21-29
543	Female, Single – 30-39
544	Female, Single – 40-49
545	Female, Single – 50-59
546	Female, Single – 60-69
547	Female, Single – 70-79
548	Female, Single – 80-89
550	Married, Unemployed – no age known
551	Married, Unemployed – 13-20
552	Married, Unemployed – 21-29
553	Married, Unemployed – 30-39
554	Married, Unemployed – 40-49
555	Married, Unemployed – 50-65
556	Married, Unemployed – 66-79
560	Married, Employed – age unknown
562	Married, Employed – 21-29
563	Married, Employed – 30-39
564	Married, Employed – 40-49
565	Married, Employed – 50-65
566	Married, Employed – over 65
570	Male – Status Unknown
580	Female – Status Unknown

600	**DEATH – CHILDREN**
610	Male, <21, age unknown
611	Male, 15 days - 6 years
612	Male, 7-12
613	Male, 13-20
620	Female, <21, age unknown
621	Female, 15 days - 6 years
622	Female, 7-12
623	Female, 13-20
631	Miscarriage, Stillborn, Newborn Babies

715	Arthritis Aggravation
711	Arthritis, Traumatic
721	Heart Damage, Original Injury
725	Heart Damage, Aggravated
730	Urino Genital – Female
739	Urino Genital – Sex Unknown
740	Urino Genital – Male
750	Parkinson's Disease
765	Ulcer, Aggravated
761	Ulcer, Traumatic
771	Hip Fracture
772	Hip Dislocation
773	Hip Abrasions or Contusions
774	Hip Bursitis or Synovitis
776	Hip Strain and Sprain
775	Hip Injury Aggravated
777	Hip Sciatic Nerve – Permanent
778	Hip Sciatic Nerve – Temporary
781	Hernia, Inguinal
782	Hernia, other than inguinal
785	Hernia, Aggravated
791	Kidney Injury
792	Kidney Loss

811	Traumatic Neurosis – no other injury
812	Traumatic Neurosis – minor injury
813	Traumatic Neurosis – serious injury
814	Mental Disorder other than Neurosis
815	Aggravation of Mental Disorder
819	Nervous System
821	Bladder Injury
831	Spleen Injury
841	Liver Injury
851	Gall Bladder Injury
855	Gall Bladder Aggravation
861	Burns
871	Cancer
875	Aggravation of Cancer
881	Electric Shock
891	Dermatitis
892	Thyroid Injury
899	Legal Theory
893	Bone Marrow
894	Transfusion-related Infection
895	Wrongful Birth
896	Body Scars

OCCUPATIONAL GROUP (Column 27)

0	Unknown
1	Skilled Tradesman
2	Professional/Executive
3	Blue Collar
4	Clerical
5	Sales
6	Self-Employed
7	Retired
8	Housewife/Student/Young Child
9	Other

MINORITY GROUP MEMBER (Column 28)

0	Unknown
1	Yes
2	No

AGE GROUP (Column 29)

0	Unknown
1	Less than 3
2	3 to 5
3	6 to 12
4	13 to 20
5	21 to 29
6	30 to 39
7	40 to 49
8	50 to 64
9	65 and older

SEX (Column 30)

0	Unknown
1	Male
2	Female

LOCALITY (Columns 31-35)

Use U.S.P.S. ZIP Code

SEVERITY OF INJURY (Column 36)

0	Unknown
1	Psychological only
2	Complete recovery — minor scar
3	Prolonged recovery
4	Pain and suffering/prolonged recovery
5	Pain and suffering/permanent injury/minor
6	Pain and suffering/permanent injury/significant
7	Great pain/prolonged suffering/permanent injury/major
8	Grave permanent injury/lifelong care
9	Death

OUTSTANDING ATTORNEY (Column 37)

0	Unknown
1	Yes
2	No

ACCIDENT/INJURY RELATIONSHIP CONTESTED (Column 38)

0	Unknown
1	Yes
2	No

DOCTRINE (Column 39)

0	Unknown
1	Res Ipsa Loquitur
2	Further action at law known
3	blank
4	blank
5	blank
6	blank
7	blank
8	Combination of 1 and 2
9	other

DURATION (Columns 40-41)

Court or Panel
Time in Days

ADDITIONAL CARD (Column 42)

1	Yes
2	No

Appendix B
Comparative Cost Methodology

A. INTRODUCTION

Figures B-1 through B-5 show the specific prehearing and hearing tasks for which time estimates were obtained for litigation and each alternative to it for the three base cases:

- Case A, light severity of injury, was representative of severity levels 1, 2, and 3.
- Case B, the mid-range of injury severity cases, combined severity levels 4 and 5.
- Case C, the severe injury range, comprised severity levels 6, 7, and 8.

Severity level 9, death, was not treated discretely because complexity of issues and trial costs tend to center in the mid-severity range (represented in this analysis by Case B).

Because comparative cost magnitudes were to be the focal point of the cost analysis, it was deemed more important to secure consistency in costing the five alternatives (the common-denominator approach) than to involve case complexity or legal procedure nuance. Emphasis, therefore, was first placed on identifying all tasks and items that incur cost in each alternative to ascertain that no significant aspect of usual procedure was left out.

Next, following the formats shown in Figures B-1 through B-5, best legal-experience estimates of task and item quantity per case for each alternative were obtained. Concurrently, costs and cost factors for the tasks and items were obtained. Finally, quantity estimates and cost factors were combined to produce the total case costs.

Task	Time in Hours	
	Plaintiff Attorney	Defense Attorney
Interviews with clients and observing witnesses		
Legal research		
Medical research		
Writing the complaint (declaration)		
Writing the answer to complaint		
Writing interrogatory questions		
Writing interrogatory answers		
Deposition of plaintiff		
Deposition of plaintiff's observing witnesses		
Deposition of plaintiff's expert witnesses		
Deposition of defendant		
Deposition of defendant's observing witnesses		
Deposition of defendant's expert witnesses		
Settlement and pretrial conferences		
Writing pretrial statements		
Consultations with expert witnesses		
Total Hours		

FIGURE B-1.
ATTORNEY PREHEARING PHASE TASKS FOR MEDICAL MALPRACTICE LITIGATION AND ALTERNATIVES TO LITIGATION

Task	Time in Hours	
	Plaintiff Attorney	Defense Attorney
Jury selection		
Opening arguments		
Plaintiff's testimony (direct and cross)		
Plaintiff's observing witnesses' testimony (direct and cross)		
Plaintiff's expert witnesses' testimony (direct and cross)		
Defendant's testimony (direct and cross)		
Defendant's observing witnesses' testimony (direct and cross)		
Defendant's expert witnesses' testimony (direct and cross)		
Argument at law (collective total)		
Closing arguments		
Jury instructions		
Jury consideration		
Total Hours		

FIGURE B-2.
ATTORNEY HEARING PHASE TASKS

Task	Time in Hours	
	Plaintiff's Witnesses	Defendant's Witnesses
Prehearing		
Investigation of records		
Consultations with attorneys		
Depositions		
Hearing		
Testimony		
Total Hours		

FIGURE B-3.
EXPERT WITNESS TASKS

Task	Time in Hours	
	Plaintiff	Defendant
Secretarial		
Stenography at deposition		
Total Hours		

FIGURE B-4.
SECRETARIAL AND STENOGRAPHIC PREHEARING TASKS

Items	Costs in Dollars		Costs Borne Elsewhere*
	Plaintiff	Defendant	
Hearing Costs (As Relevant)			
Jury			
Recorder			
Arbitrator			
Total			
Other Costs (As Relevant)			
Judge Pro-Rata Salary			
Medical and Legal Panelists			
Expert Witnesses for Panel			
Plaintiff			
Defendant			
Observing Witnesses			
Total			
*See text for explanation.			

FIGURE B-5.
COURT COSTS AND "OTHER" COSTS

Controlled Experiments in Establishing and Operating Medical-Legal Screening Panels

The problems inherent in establishing and operating screening panels could be analyzed and documented in the format of a manual of guidelines and procedures, to assist those jurisdictions planning to establish a screening panel. It is recommended that a set of guidelines be developed and applied on a trial (pilot) basis in several areas of differing socio and demographic characteristics. Procedures would then be refined to overcome the particular problems associated with effective institution of these voluntary plans in each area, making use of experience data collected under the information exchange program outlined above.

B. APPLICATION OF THE COST COMPARISON METHODOLOGY

Table B-1 lists the quantitative cost and cost factor assumptions used in the analysis. Table B-2 shows the assumptions made about trial times (in days) and screening panel and arbitration hearing times (in hours). These estimates, as well as the ones in Table B-3 (which relate to representative numbers of expert witnesses, number and profession of screening panel members, and composition of groups attending trials, panels, and arbitration) were provided by experts experienced in the medical malpractice field.

Representative cost factors are difficult to obtain for pricing medical-legal disputes. There is an abundance of data pertaining to settlements, verdicts, and the sharply increasing premium cost of medical malpractice insurance, but there is little hard data pertaining to the cost of standard procedural items and affected or involved personnel. A further in-depth analysis into out-of-pocket cost aspects of medical malpractice lawsuits would undoubtedly produce interesting and highly useful results.

Table B-4 shows the total costs for the fifteen specific litigations and alternatives costed. Each of the fifteen case costs is broken down into component parts: plaintiff total, defendant total, and "other items" total cost. In addition, the relative cost of each component is shown as a percentage of total case cost.

C. SOME GENERAL OBSERVATIONS AND TESTS OF COST VALIDITY

Although the methodology used in comparative costing of litigation and its alternatives across the range of injury severity is simple, all important elements of cost have been included. Current cost factors—representing "going" rates, plus experience-based value judgments about the reasonable quantity and type of each item and task priced out—have combined to invest this cost analysis with validity for purposes of comparing the relative costs of medical malpractice alternatives to actions at law *for the samecase*.

Finally, with respect to the reasonableness of the actual dollar values in the total cost estimates, there are some clues suggesting rough magnitudes of action-at-law dollars and some hints of the qualitative savings possible through the medical-legal screening panel medium.

One data source[48] sets a range of trial expenses—inclusive of the entire severity range—at somewhere between $400.00 and $2,200.00. In this reported study, results were obtained from both a nationwide survey of attorneys without regard to specialty of practice and a survey of selected attorneys who specialize in medical malpractice work. While all the respondents in both surveys agreed on little else in terms of the dollar values of recovery cost components, they did seem to agree generally on the range of expense costs.

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[48] "The Medical Malpractice Legal System," *Infra*, p. 00. See especially Supra, pp. 87 ff, Tables III-29, III-30, and III-31.

TABLE B-1.
COSTS AND COST FACTORS

Item	Cost or Cost Factor	Comments on Cost Allocation
Attorney Fee	$50/Hour	
Expert Medical Witness	$100/Hour	
Professionals (includes Panel Members and Defendants	$50/Hour	
Judge (Pro-Rata Salary)	$200/Day	
Arbitrator	$300/Case	1/2 to plaintiff, 1/2 to defense
Plaintiff and Observing Witness	$5/Hour	
Secretary	$5/Hour	
Stenographer	$25/Hour	
Court Recorder	$25/Hour	On basis of 2-to-1 decisions for defense, distribute cost 2/3 to plaintiff, 1/3 to defense
Jury	$110/Day *	Same as for court recorder

* Jury costs are averaged from case records obtained from Jury Verdict Research, Incorporated.

TABLE B-2.
TRIAL AND HEARING TIMES

Type of Hearing	Case	Days *	Hours
Actions at Law	Case A	3	
	Case B	5	
	Case C	8	
Screening Panels	Case A		2
	Case B		3
	Case C		4
Arbitrations	Case A		6
	Case B		8
	Case C		8

* Jury Verdict Research, Inc., data relating actual trial days and severity levels five 4, 6.5, and 9 days. The estimates in the table are representative.

TABLE B-3.
NUMBERS OF PARTICIPANTS (BASIS FOR ESTIMATES: "MOST LIKELY" PARTICIPATION)

Type of Participant and Function	Action at Law	Physician Panel	Medical-Legal Panel	Court-Sponsored Panel	Arbitrations
Decision Makers					
Doctors		5 (Range 3-10)	3 (Range 2-10)	1	Arbitrator, Profession Unknown
Lawyers		1	3 (Range 2-10)	1	
Judges	1			1	
Jurors	12				
Litigants					
Plaintiff	1		.5	.5	1
Defendant	1	1	.5	.5	1
Plaintiff Attorney	1		1	1	1
Defense Attorney	1		1	1	1
Witnesses	Case A B C	Case A B C	Case A B C	Case A B C	Case A B C
Expert for Plaintiff	1 2 3	0 0 0	0 .5 1	.5 1 2	.5 1 2
Expert for Defendant	1 2 3	0 0 0	0 .5 1	.5 1 2	1 2 3
Observing, Plaintiff	1 1 1				
Observing, Defense	1 1 1				

Note: Whole numbers in table indicate full-time attendance, decimal numbers indicate may or may not attend

TABLE B-4.
TOTAL AND RELATIVE (PERCENTAGE COST PER CASE FOR PLAINTIFF, DEFENDANT, AND OTHER ITEMS NOT PAID FOR BY PARTIES

Item	Total Cost, Plaintiff		Total Cost, Defendant		Total Cost, Other		Grand Total	
	$	%	$	%	$	%	$	%
Case A								
Actions at Law	8,593	49.2	7,462	42.8	1,400	8.0	17,455	100
Screening Panels								
Physician	1,965	46.8	1,929	36.4	700	16.8	4,594	100
Medical-Legal	4,505	50.4	4,025	45.0	405	4.6	8,935	100
Court-Sponsored	7,250	52.2	6,295	45.3	350	2.5	13,895	100
Arbitration	6,800	50.7	6,270	46.8	330	2.5	13,400	100
Case B								
Actions at Law	12,975	47.9	11,850	43.7	2,280	8.4	27,105	100
Screening Panels								
Physician	2,130	38.6	2,335	42.2	1,064	19.2	5,529	100
Medical-Legal	6,110	47.9	5,580	43.7	1,072	8.4	12,762	100
Court-Sponsored	10,465	50.4	9,860	47.4	465	2.2	20,790	100
Arbitration	10,090	49.2	9,975	48.6	440	2.2	20,505	100
Case C								
Actions at Law	16,902	46.9	15,553	43.1	3,600	10.0	36,055	100
Screening Panels								
Physician	2,250	35.5	2,690	42.4	1,400	22.1	6,340	100
Medical-Legal	1,365	47.1	6,935	44.4	1,320	8.5	15,620	100
Court-Sponsored	13,430	49.8	12,925	47.9	610	2.3	26,965	100
Arbitration	12,760	48.5	13,085	49.8	440	1.6	26,285	100

ALTERNATIVES TO LITIGATION, II: CONSTITUTIONALITY OF ARBITRATION STATUTES

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Summary

There is widespread interest within the professional liability insurance and medical care delivery industries in employing the dispute resolution technique of arbitration to medical malpractice claims. This substitution of a private, contractually established tribunal for the courts presents a number of questions about the legality of doing so. This paper analyzes the more significant legal problems associated with applying the arbitral technique in the medical malpractice claims arena and assesses the current readiness of statutory and common law in the 50 states and the District of Columbia to accept it.

The objection most frequently asserted by laymen to the use of arbitration is of constitutional dimensions—that it deprives the claimant of his right to trial by jury. As will be discussed in the following pages, this suggestion is without merit; however, there are numerous and subtle issues within the fabric of the substantive law of contracts which could prevent the enforceability of arbitration agreements by the courts prior to their reaching any question of constitutional merit.

The constitutionality of arbitration agreements is discussed by analyzing three model health care delivery frameworks in which arbitration might be employed—a federal model where an agreement to arbitrate disputes would be incorporated in a federally sponsored plan of health insurance; a state model similar to the federal model; and a state statutory framework providing for the arbitration of medical malpractice disputes unfettered by a health insurance plan.

Principal among the constitutional issues analyzed are whether arbitration involves an unlawful delegation of legislative or judicial power to the arbitration tribunal; whether it violates the guarantee of due process of law; whether it brings about a deprivation of the right to trial by jury; and whether it results in a denial of equal protection.

With careful statutory drafting to avoid unique facets of the law of some states, it is concluded that a medical malpractice arbitration plan will survive the test of constitutionality under any theory of objection so far devised.

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I. Introduction: The Evolution of the Constitutional Challenge

The practice of arbitration represents an attempt by contracting parties to provide for extra-judicial resolution of their disputes. The common law, jealous of its jurisdiction, generally took a dim view of agreements to arbitrate, and it was repeatedly held in the early part of this century that such accords were contrary to public policy and unenforceable.[1] Legislative dissatisfaction with the revocability of private arbitration agreements led in the early 1920s to the passage of "modern arbitration acts"; these statutes, now in effect in 30 states and at the federal level,[2] provide that written agreements to arbitrate any dispute, existing or prospective, are "valid, enforceable, and irrevocable."[3] Contracting parties thereby became bound to the decision of the arbitrator; it therefore became necessary for those seeking to circumvent that decision to attack the constitutionality of the arbitration statute from which it derived its effect. From the early delineation of these constitutional challenges to arbitration statutes on both the state and federal levels evolved a series of legal myths about the validity of the arbitration process. Principal among these constitutional myths are that arbitration involves an unlawful delegation of legislative or judicial power, that it violates the guarantee of due process of law, that it brings about a deprivation of the right to trial by jury, and that it results in the denial of equal protection. This paper will examine in turn each of these enduring myths and will attempt to assess their potential contemporary impact on the constitutionality of a variety of models, set forth hereinunder, for the compulsory arbitration of medical malpractice claims.

II. The Arbitration Models

The constitutional validity of medical malpractice arbitration schemes will, of course, depend on the particular features of the plan. It is useful, therefore, briefly to describe the basic attributes of these possible arbitration models; one model envisages a federally sponsored, nationwide health insurance program, the other two more limited plans enacted by the states on an individual basis.

A. THE FEDERAL MODEL

As a prerequisite to participation in a national plan of health insurance, it might be required of subscribers that they agree to submit to binding arbitration any malpractice claims arising out of treatment subsidized by the plan. Such indeed is an element of the so-called "Kennedy Health Care Bill"[4] now under consideration in Congress: the insured would enter into an agreement for binding arbitration with the provider of health care, the validity of the agreement to be determined in accordance with the Federal Arbitration Act. The Federal Act by its terms is limited "a contract evidencing a transaction involving interstate commerce."[5] Congress, in providing for arbitration under the Federal Act of claims arising out of treatment, would therefore be declaring that contracts, entered into under the aegis of the plan between patients and providers of health care, do in fact involve interstate commerce—otherwise Congress could not stipulate arbitration under the Federal Act. The congressional declaration is not, as a practical matter, subject to any kind of challenge; the expansive reading of the commerce clause power almost inevitably leads the Supreme Court to find a rational basis for Congress' finding that a particular transaction sought to be regulated evinces attributes of interstate commerce.[6]

B. STATE MODEL I

A state might choose to establish within its own jurisdiction a health insurance plan with an arbitration feature similar to that contained in the federal scheme outlined above. As has been done in the context of no-fault automobile insurance legislation, the medical insurance statute in this model would provide that malpractice claims stemming from state-subsidized treatment be submitted to binding arbitration. The constitutional question here will focus on the power of the state to require arbitration, as well as on the procedural fairness of the arbitration hearing itself.

C. STATE MODEL II

A third possibility is that a state might simply by statute require that all medical malpractice claims be submitted to arbitration, despite the noninvolvement of the state itself in any aspect of the health care delivery process. The effect of such a statute would be to include an obligatory arbitration clause in every contract of admission to a hospital.

In all three of these models, a legislative body is undertaking to encourage, and in some instances demand, extra-judicial resolution of a closely defined category of disputes. In the discussion that follows, we will examine a variety of putative constitutional challenges to such enactments in an effort to answer two basic questions about the power of a legislature, whether federal or state, to take measures of this nature: Is arbitration in any context a constitutional alternative to the traditional position of the courts as exclusive fora for the resolution of legal disputes? If so, what procedural safeguards are constitutionally required of a medical malpractice arbitration board?

III. The Constitutional Issues

A. UNLAWFUL DELEGATION

Perhaps the earliest challenge made to arbitration panels set up at the instance of the legislature was that there occurred thereby an excessive delegation of judicial power to nonjudicial persons. In a Texas case, *Board of Water Engineers v. McKnight*,[7] the court held invalid a legislative attempt to vest in an administrative body jurisdiction over private water rights disputes. Said the court, ". . . it would be hard to state a more patent attempt by the legislature to confer judicial power on a nonjudicial tribunal than for the legislature to enact that such tribunal shall be authorized to determine cases pending in court between private litigants."[8] Nor in this instance was the statute saved from invalidity by an explicit provision for appeal to a court trial *de novo*. Similar exception was taken in New Hampshire to a statute providing for administrative determination of auto accident suits.[9] It seems likely, in both these cases, that the results turned as much on the fact of non-consensual imposition of arbitration upon private parties as on the courts' concern for the dilution of judicial powers. Indeed, courts have uniformly upheld the "modern arbitration acts" declaring effective and enforceable private agreements to arbitrate—in the face of just such unconstitutional delegation arguments.[10] One state court rejected a delegation challenge to an arbitration statute with the observation that "the legislature has provided a statutory method of arbitration, and the only effect on the jurisdiction of the court is that the statute provides a summary means by which arbitration agreements are to be enforced."[11]

It is now generally recognized that the role of arbitration boards is supplementary to, rather than pre-emptive of, the jurisdiction of the courts. The earlier hostile posture of the judicial establishment has been reversed, and judges today are more apt to find in arbitration statues a compelling expression of legislative policy favoring private resolution of disputes.[12] The claim that the legislative provision of a board for the arbitration of medical malpractice suits involves an excessive delegation of judicial power is unlikely, therefore, to meet with any contemporary success.

It has sometimes been claimed that the legislature has acted unconstitutionally in establishing arbitration panels without providing the arbitrators with adequate standards on which to base their decisions. This is a variation on the familiar theme that quasi-judicial and rule-making entities must follow legislative signposts and may not be left to their own devices in the adjudication of matters brought before them. In the case of arbitration panels designed for the resolution of malpractice claims, it should be adequate to provide that the "standard" of decision-making will be ordinary negligence law.

B. DUE PROCESS

It is axiomatic that procedures employed by arbitration panels must be so designed as to preserve for the litigants the guarantee of "due process of law." On the federal level, the guarantee is embodied in the Fifth Amendment, and every state constitution contains language equivalent in scope. No malpractice arbitration panel could long survive which did not, to take the extreme example, provide litigants with the opportunity to be heard.

Due process objections brought against arbitration statutes have been, by and large, imprecise, and no case has been found in which an arbitration award was overturned because of a denial of procedural due process. Many courts have limited themselves to curt rejections of generalized procedural due process assaults on the legitimacy of arbitration panels,[13] and it is likely that procedures conforming to those suggested by the Uniform Arbitration Act[14] represent a constitutional sufficiency of safeguards. A malpractice plaintiff must be allowed to appear before the panel, to present evidence material to the controversy, and to cross-examine witnesses at the hearing. It is possible, of course, that future court decisions may expand the rights of parties to arbitration proceedings in such areas as discovery and deposition; it is not to be anticipated, however, that such minor procedural modifications as may from time to time become necessary will present an insuperable burden to the arbitration machinery.

C. EQUAL PROTECTION

The Fourteenth Amendment provides that no state shall deny to any person "the equal protection of the laws"; this guarantee has been held applicable to the Federal Government by process of "incorporation" into the Fifth Amendment.[15] Very simply put, this guarantee translates into a requirement that legislatures enact no laws which, without a "rational basis" therefor, apply to certain categories of persons, objects, or transactions, but not to others.[16] Such is the constitutional foundation for equal protection claims directed against statutes which provide that only some classes of claims, involving less than a certain amount of money, will be subject to compulsory arbitration, or alternatively, that the amount of arbitration awards will be statutorily limited only with respect to claims stemming from injustices of a certain kind.

In Pennsylvania, for example, the compulsory arbitration statute applies only to claims of $3,000 or less. In Illinois, the no-fault automobile insurance statute imposes a ceiling on the dollar amount of arbitrators' awards thereunder, but only with respect to claims arising from collisions involving private, noncommercial vehicles. Each of these statutes was attacked, on the basis of its classifications, as violative of equal protection, or, similarly, as contrary to a state constitutional prohibition against the passage of "special laws". The Pennsylvania statute was upheld;[17] the Illinois statute was struck down.[18] The divergent results can be explained by the difference between the two courts in the extent to which each was prepared to accept as "reasonable" the classifications established by the respective legislatures. The standard of judicial review, as stated above, is a familiar one: laws will be upheld if the classifications they establish are founded on a "rational basis".[19] On the basis of the decided cases, the implications for medical malpractice arbitration might take the following form: a statute will be upheld which provides, for example, that only malpractice claims involving less than $10,000 will be arbitrated, while a statute limiting arbitration to malpractice claims arising out of, say, tonsillectomies probably would be struck down as violative of equal protection. In Model I, therefore, any congressional limitation on compulsory arbitration to certain categories of illnesses or operations should be buttressed by findings tending to show a rational basis for the classification; the same is true for the state legislatures in the other models.

It would seem that any number of justifications might be put forward to explain the requirement of arbitration of medical malpractice suits alone, while parties to other kinds of litigation are free to provide for or reject arbitration as they see fit. One might cite in this connection the volume of malpractice litigation, the special burdens of delay on patients and health care providers alike, the requirement of uniformity in the size of damage awards in the context of a governmental scheme of health insurance.

One should mention, as a subsidiary example of the equal protection argument as applied to arbitration, a quixotic "one man, one vote" challenge recently brought against a Pennslyvania statute authorizing establishment of an arbitration panel to mediate disputes involving public employees and police officers.[20] The theory of the suit was that the decision of the panel would determine the spending of public money—a legislative function—and that the manner in which the quasi-legislators had been appointed violated the "one man, one vote" principle. A medical malpractice arbitration panel established in connection with a government-funded insurance program would likewise, in a sense, determine the size of allocations to be made in the form of damage awards out of the public treasury. The case, in any event, illustrates only the extent of the originality now required of those who seek to question the constitutionality of arbitration; the court simply pointed out that arbitrators, as non-legislative officers, can be appointed without regard to one man, one vote considerations.[21]

D. JURY TRIAL

The argument that arbitration involves the deprivation of the right to trial by jury belongs, as a theoretical matter, in the section dealing with procedural due process. The claim, however, is a substantial one and merits separate consideration.

The right to trial by jury in civil matters is set forth in the Seventh Amendment. It is therefore relevant to federal arbitration machinery. The Seventh Amendment, however, has not been incorporated into the Fourteenth Amendment, and is inapplicable to the states.[22] The Supreme Court has spoken of the need to permit the individual states some latitude for experimentation in this area.[23] As a practical matter, of course, jury trial is in any event guaranteed by 48 out of the 50 state constitutions.[24] The potential effect of non-incorporations lies in the fact that a hypothetical federal decision, holding that arbitration necessarily led to denial of the right to jury trial, would not bind state arbitration panels in their treatment of the same question.

There is a very ancient precedent for the proposition that the right to jury trial is denied where the law compels a party to arbitrate a claim which properly could be the subject of a civil suit.[25] A distinction must be drawn, however, between directly coercive statues compelling arbitration without recourse and statutes designed merely to aid the courts by providing for arbitration in certain cases but preserving a right of appeal to the courts. It was by pointing to the latter model that the Pennsylvania Supreme Court in the important case of *In Re Smith*[26] was able to uphold the Pennsylvania compulsory arbitration law:

> Although a statute the effect of which is to compel parties to submit to arbitration is unconstitional. . . this is so only where the statute closes the courts to litigants and makes the decision of the arbitrators the final determination of the rights of the parties, and there is no denial of the right to trial by jury if the statute preserves that right to each of the parties by the allowance of an appeal [with jury trial] from the decision of the arbitrator or other tribunal-and such a right was here provided.

The provision of right to appeal therefore operates to cure the putative constitutional defect, to the extent at least that the right to post-arbitration jury tiral is not fettered by conditions so unreasonable as to make it practically unavailable. The Pennsyvlania court found that a requirement that the appealing party repay to the county the $85 in arbitrators' fees did not constitute an impermissible obstacle to jury trial. It is worth noting that the court thereby conserved the essential utility of the arbitration proceeding by discouraging routine "appeal" by the loser to the courts.

The Illinois Supreme Court, on the other hand, recently invalidated that state's no-fault automobile insurance statute, on the ground, among others, that the arbitration provisions, notwithstanding the availability of appeal, worked a denial of the right to jury trial.[28] The case turns, insofar as this point is concerned, upon a provision of the Illinois constitution prohibiting trials *de novo*: the court held that any post-arbitration appellate proceeding would of necessity be in the nature of an impermissible trial *de novo*, and that because an appeal was therefore unavailable the right to jury trial had been denied. It was on this basis alone that the court was able to distinguish *In Re Smith*, and it is not likely that many state constitutions will share Illinois' disapprobation of *de novo* proceedings. *Grace v. Howlett* may well represent an example of lingering judicial hostility to arbitration in general; but the case, it is submitted, can readily be limited to its rather peculiar facts.

It is not surprising that no federal court should yet have had to pass on the relationship of the Seventh Amendment to arbitration proceedings under federal statutes. Apart from the special case of labor arbitration statutes, to be dealt with below, no federal legislation has ever set out to provide for compulsory and binding arbitration of disputes. Cases brought under the Federal Arbitration Act involve the enforceability of private, consensual arbitration agreements, and right to trial by jury is deemed to have been waived by consent to arbitration under both state and federal "modern arbitration acts". The contending parties have simply contracted that the merits of their controversy shall be conditioned upon the report of the arbitrators, as upon any other extrinsic fact which agreement might prescribe.[29] The question therefore arises whether a participant in the Model I plan schematized above might not similarly be deemed to have "voluntarily waived" his right to jury trial, making superfluous the position for appeal. The difficulty is that neither participation in the plan nor consent to arbitration can be said to have been "voluntary" in the real sense of the word.[30]

One's confidence in the immunity of arbitration statutes to "jury trial" challenges is reinforced by the fact that both state and federal statutes whose inroad on the right to jury trial is most obvious—compulsory workmen's arbitration acts—have consistently been upheld by the courts.[31] While these statutes are readily distinguishable because the conflicts which they undertake to regulate would not necessarily be cognizable in any civil court,[32] they are symptomatic of the increasing realization of the sheer administrative necessity for some form of preselection of litigation which does ultimately reach the courts. In light of these factors, one can say with a reasonable degree of certainty that a medical malpractice arbitration statute which made elementary provision for post-award jury trial would be impervious to constitutional attack on deprivation of jury trial grounds.

E. MISCELLANEOUS CONSTITUTIONAL CHALLENGES

Isolated cases have been found in which arbitration statutes have been attacked on such diverse additional theories as that they impair the obligations of contracts,[33] and that they violate constitutional prohibitions against "fee officers" in the judicial system. In *Grace v. Howlett*,[34] for example, a provision of the no-fault insurance arbitration plan would have required the losing litigant to pay the fees of the arbitrators, which fees, said the court, were treated as costs. It is evident that malpractice arbitration statutes enacted in accordance with Model II will be able to take account of the idiosyncracies of individual state laws on such severable issues as arbitrators' fees, and that any potential constitutional pitfalls of that nature can readily be circumvented in the drafting stage.

IV. Conclusion

Such, then, are the myths surrounding the constitutionality of arbitration statutes. Most have already been exploded by the courts, and the judicial establishment has been increasingly inhospitable to suits alleging constitutional deficiencies in arbitration. It is the opinion of this observer that, given some attention by legislative draftsmen to the caveats above set forth, a medical malpractice arbitration plan, devised along the lines of any of the three models described in Section II, will survive the test of constitutionality under any theory so far devised.

1. For a compilation of decisions to that effect, see Annot., 135 A.L.R. 79 (1941). In the absence of modification by statute, the common law doctrine appears to remain in force, see, e.g., Green v. Wolff, 140 Mont. 413, 372 P.2d 427 (1962), although a few courts have by decision declared valid and enforceable future arbitration clauses, Cf. Exell v. Rocky Mt. Bean & Elevator Co., 76 Colo. 409, 232 P. 680 (1925).
2. For a state-by-state compilation, see Aksen, Resolving Construction Contract Disputes Through Arbitration, 23 Arb. J. 141, 149-51 (1969).
3. See, e.g., Section 1 of the Uniform Arbitration Act, 9 Uniform Laws Ann. 78 (1957).
4. Health Maintenance Organization and Resources Development Act of 1972, S. 3327, 92d Cong., 2d sess. (1972). The bill was referred to committee in the last session and presumably will be resubmitted to the 93rd Congress.
5. 9 U.S.C.A. sec. 3 (1970).
6. The case of Wickard v. Filburn, 317 U.S. 111 (1942) and its long line of progeny are illustrative of the reluctance of the court to second-guess a congressional determination that a given transaction "affects interstate commerce" and is therefore within the regulatory search of Congress' power under the commerce clause.
7. 111 Tex 82, 229 S.W. 301 (1921).
8. 229 S.W. at 304.
9. In Re Opinion of the Justices, 87 N.H. 492, 179 Atl. 344 (1935).
10. See, e.g., Sommer v. MacKay, 10 N.J. Misc. 644, 160 Atl. 495 (1932); Snyder v. Superior Court of Amador County, 24 Cal. App. 2d 263, 74 P.2d 782 (1937).
11. Tuschman Steel Co. v. Tuschman, 181 N.E. 2d 322 (N.Y. 1961).
12. See Gregg Kendall v. Associates, Inc. v. Kauhi; 488 P.2d 136 (Hawaii, 1971).
13. E.g., Division 85, Amalgamated Transit Union v. Port Authority of Allegheny County, 417 Pa. 299, 208 A.2d 271 (due process argument "totally lacking in merit"); Finsilver, Still & Moss v. Goldberg & Co., 253 N.Y. 382, 171 N.E. 579 (1930).
14. Cf. sec. 5, 7, Uniform Arbitration Act, 9 Uniform Laws Ann. 78 (1957).
15. See Bolling v. Sharpe, 347 U.S. 497 (1954).
16. See Williamson v. Lee Optical Co., 348 U.S. 483 (1955). The legislature need demonstrate a "compelling state interest" in the classification only where the basis for the distinction is "suspect", i.e., involving race, sex, wealth, or touching the exercise of a fundamental right. Compare Harper v. Virginia Bd. of Elections, 383 U.S. 663 (1966).
17. In Re Smith, 381 Pa. 223, 112 A.2d 625 (1955).
18. Grace v. Howlett, 283 N.E. 2d 474 (Ill. 1972). This case is considered in greater detail infra with respect to its holding on the right to jury trial.
19. See Day Brite Lighting Inc. v. Missouri, 342 U.S. 421 (1952); Pacific Indem. Co. v. Ins. Co. of North America, 25 F.2d 930 (9th Cir. 1928) (arbitration statute limited to labor contracts reflects "permissible classification").
20. Harvey v. Russo, 435 Pa. 183, 255 A.2d 560 (1969).
21. The court relied on Sailors v. Bd. of Educ., 387 U.S. 105 (1967), which upheld a procedure for choosing a school board that placed the selection with school boards of component districts even though the component boards had equal votes and served unequal populations. The court rested on the administrative nature of the board's functions, and the essentially appointive form of the scheme employed. Clearly the arbitration panel is likewise nonlegislative in function, and appointive rather than elective in form.
22. Walker v. Sauvinet, 92 U.S. 90 (1875); Wagner Elec. Mfg. Co. v. Lyndon, 262 U.S. 226 (1923).
23. Cf. Johnson v. Louisana, 40 L.W. 4524 (1972).

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24. Louisana and Colorado are the exceptions.
25. See Annot., 55 ALR 2d 437, sec. 5, and cases cited therein.
26. 381 Pa. 223, 112 A.2d 625 (1955).
27. 112 A.2d at 625.
28. Grace v. Howlett, 283 N.E. 2d 474 (Ill. 1972).
29. See Berkovitz v. Arbib & Haulberg, 230 N.Y. 261, 130 N.E. 288 (1921).
30. The question is essentially one for contract law, and is not developed further here. For an illuminating discussion of the element of consent in medical malpractice arbitration contracts, see "Alternatives to Litigation, III," *Infra*, pp. 321 ff.
31. Hardware Dealers' Mut. Fire Ins. Co. v. Glidden Co., 284 U.S. 151 (1931); N.Y. Cent. R.R. v. White, 243 U.S. 188 (1917) (state statute); Bhd. of R.R. Trainmen v. Chicago R.R. & Ind. R.R., 353 U.S. 30 (1957) (federal statute).
32. One refers in particular to such extra-contractual bones of contention as working conditions, mechanization, featherbedding, and the like.
33. Berkovitz v. Arbib & Haulberg, 230 N.Y. 261, 130 N.E. 188 (1921).
34. Grace v. Howlett, 283 N.E. 2d 474, 481 (Ill. 1972).

ALTERNATIVES TO LITIGATION, III: CONTRACTUAL PROBLEMS IN THE ENFORCEMENT OF AGREEMENTS TO ARBITRATE MEDICAL MALPRACTICE

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Summary

Largely overlooked in discussing the framework of the legal system in accommodating arbitration contracts are the many implicit challenges to the enforceability, formation, party capacity, and equality of bargaining power, and special problems inherent in the widespread use of arbitration agreements in the medical setting. It is in this sphere of the law that the harder tests of the mettle of arbitration agreements will first be encountered, and a number of significant difficulties must be overcome.

It is concluded that the response of the courts to the arbitration of medical malpractice claims hinges greatly on public expectation when the bargain for medical services is made. The belief that arbitration furthers the interests of the medical patient must be evolved by careful and sensitive medical industry practices and marketing techniques, with evidence of a real and informed choice by the patient to waive access to the courts.

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I. General Structure of the Law of Enforceability of Arbitration Agreements

Arbitration begins with and depends upon voluntary agreement. Absent an enforceable contract to submit a claim arising out of medical care for binding third-party determination, there is no right to invoke, or power to compel, arbitration as a method of adjudication. Thus any attempt to extend the mechanism of arbitration[1] to the field of medical malpractice must inevitably anticipate problems raised by the general law of contracts.

The role of contract law in a system of commercial arbitration is in large measure determined by the impact of various state and federal arbitration statutes upon entrenched judicial rules and attitudes. Arbitration agreements are enforceable currently largely because of modern legislation, the principal effect of which is to reverse the traditional common law view that agreements to arbitrate disputes arising subsequent to the making of the agreement are contrary to public policy and unenforceable.[2] Since agreements to arbitrate a controversy already in existence have historically received different and favorable treatment by the courts,[3] the restrictive common law rule was apparently premised on the belief that unlimited delegation to lay persons of judicial powers respecting unknown future disputes is inherently objectionable.[4]

Whatever its rationale, the net result of the doctrine of revocability of executory agreements was that each contractual party enjoyed a power to effectively resist, and thereby sabotage, arbitration at any time prior to rendition of the award.[5] The arbitration agreement not being specifically enforceable in court, nor sufficient to stay a court action based on the disputed claim, only a damage remedy for breach of the contract to submit to arbitration was available. The damage remedy remains notoriously inadequate because of the continuing rule that only nominal damages are recoverable for breach or repudiation of such agreements.[6]

Legislative change was not unexpectedly preceded by considerable dissatisfaction with the rule of revocability. Indeed, it is common practice today to categorize and measure the worth of arbitration statutes on the basis of the degree to which agreements to arbitrate future disputes are made irrevocable and a procedure is supplied for compelling arbitration in accordance with an agreement to do so. The distinguishing feature of the most advanced statutes, popularly known as "modern arbitration acts" and in effect in 30 states and at the federal level,[7] is a declaration that written agreements to arbitrate any dispute, existing or prospective, are "valid, enforceable and irrevocable."[8] This approach is to be contrasted with that of a number of states which, in giving legislative sanction to commercial arbitration, carry forward the common law distinction between executory agreements and the submission of pending disputes. In these states only agreements to arbitrate existing controversies are statutorily validated, the legislation being silent with respect to contracts to arbitrate future disputes.[9] Most of the courts which have considered the legal status of executory arbitration agreeements in such jurisdictions have concluded that the common law rule of revocability applies.[10] Still other states, though few in number, have failed to enact any legislation dealing with commercial arbitration.[11]

At the threshold of every proceeding to compel arbitration is the question of the source of controlling law and procedure. Given the movement toward statutory solution, an obvious issue is the remaining vitality of common law arbitration. The situation in any single state will of course depend on the interaction of the legislation and case law of that state. However, a few working principles supply general guidance. Even though fragile because of the revocability rule, the common law concept of arbitration survives in almost all jurisdictions, not solely those without any form of statute. This is so because statutes which establish a system of arbitration do not expressly abolish common law arbitration.[12] Hence, since common law arbitration prevails generally except to the extent superseded by statutory regulation, parallel systems of arbitration coexist in most jurisdictions. The practical significance of potentially concurrent systems is that the common law may well supply some measure of enforcement in the event of deviation from a statutory procedure or form of agreement.[13]

Identification of the law and procedure controlling an arbitration agreement may encounter difficulties in a second problem area. If a state has an arbitration statute of limited scope, or none at all, or if the use of a state statute is precluded for some reason, or a party simply prefers to avoid state proceedings for tactical reasons, enforcement of the agreement may well be available under the United States Arbitration Act (Federal Act). Apart from maritime transactions, the Federal Act by its terms is limited to "a contract evidencing a transaction involving commerce."[14] For purposes of this discussion, it is sufficient to observe that a generally expansive reading of the "commerce" requirement, approved by the Supreme Court,[15] means that the Federal Act will continue to enjoy wide application. The resulting interplay of the Federal Act and state law raises important and unsettled question,[16] only some of which are within the scope of this paper.[17]

Assuming an action based on diversity of citizenship and involving an arbitration clause in a contract evidencing a transaction in interstate commerce, the central issue is whether state or federal law should govern the interpretation and validity of the arbitration agreement. Presumably state law is solely applicable to contracts not satisfying the jurisdictional test of commerce.[18] But with respect to an interstate contract, the leading case of *Robert Lawrence Company v. Devonshire Fabrics, Inc.*.[19] holds that the Federal Act creates a body of national substantive law "equally applicable in state or federal courts" on questions of interpretation, validity, revocability and enforceability of arbitration agreements.[20]

While the Supreme Court in *Prima Paint* did not explicitly adopt this reasoning in full, it did embrace the concept of a body of federal common law substantively applicable to at least interstate arbitration agreements litigated in the federal courts.[21] Though the courts have differed in approach, a growing number of decisions support the view that, when an interstate transaction is involved, federal law governs questions surrounding arbitration in suits in state courts as well.[22] A choice of state law made by the contract of the parties may, however, effectively exclude the application of federal law regardless of the forum.[23] In any event, it should be emphasized that the Federal Act, being one which implements executory agreements, operates generally to enlarge the number of enforceable arbitration agreements. For example, agreements in commerce to arbitrate prospective disputes are enforceable in states with statutes extending only to existing disputes.[24] The application of federal law is additionally facilitated by the removal to a federal court of an enforcement action commenced in a state court. And even where removal does not occur, state courts may be inclined to apply the Federal Act in deference to standard preemption doctrine.[25]

In order to place the problem of enforceability of the arbitration agreement in proper perspective, it is necessary to draw some fundamental relationships between the statutory framework of arbitration and the ordinary law of contract. The decisions and accompanying literature suggest that the arbitration forum to some extent obscures the contractual underpinnings of the entire system. The point of departure is a recognition that the legislative product evidences a healthy respect for traditional notions of freedom of contract. Arbitration statutes reinforce contract values by performing functions that might be characterized as "validation" and "channeling."

The latter function is to be seen primarily in the comprehensive and systematic procedures designed to insure compliance with the parties' expressed intention to arbitrate. To illustrate, a refusal to honor an agreement to arbitrate enables the aggrieved party to apply by motion to a court for an order compelling arbitration. If a suit is filed on a claim allegedly covered by an arbitration agreement, a defendant may similarly move in that or the appropriate court for a stay of the action pending arbitration. Regardless of how enforcement of the arbitration agreement is sought or challenged, contractual issues normally are presented through the vehicle of a fixed statutory proceeding, a principal aim of which is the efficient administration of a private system for the resolution of disputes.[26] Toward this end, summary procedures are made available to compel or prevent arbitration, to review, modify or correct awards, as well as for prompt enforcement of the results of the arbitration process. Above all else, the statutes attempt to limit judicial involvement by prescribing the contractual issues a court may fairly consider.[27]

Yet the system is created, administered and controlled by the written agreement. Though arbitration statutes establish a limited number of requirements for an operative agreement, such as the formality of a writing,[28] they do not initiate or create a contract to arbitrate. Rather, the statutory scheme presumes the existence of an agreement arrived at through the usual processes of mutual assent. Apart from a policy declaration favorable to executory agreements, the statute does not purport to displace universal tests of contract formation and enforceability. Indeed, there is nothing extraordinary about arbitration agreements in the world of contract; they are handled by rules and techniques indistinguishable from those applied to contracts in general.[29]

Accordingly, even a statute which expressly modifies common law restrictions does not eliminate conventional grounds for attacking an agreement to arbitrate. Reasons sufficient to invalidate a contract in general, such as mistake, fraud or duress, are statutorily preserved as the basis for an effective withdrawal of consent to arbitrate. The point to be underscored is simply that the modern arbitration acts incorporate the standard rules of contract invalidation.[30] They neither delineate substantive law nor attempt regulation of business transactions.

Thus, ordinary contract principles determine both the applicability of an arbitration statute and liability under it. Supposedly the contracting parties retain control over the arbitration process by the language in their agreement.[31] The role in fact played by contract law will depend upon the nature and frequency of judicial interference with the arbitration process. The matter surfaces in connection with the issue of whether the court or the arbitrator has authority to decide contractual issues surrounding arbitration, a subject that will be examined at a later point.

II. Existing Patterns of Agreement to Arbitrate Medical Malpractice

The case for substitution of arbitration for court litigation of medical malpractice is at the moment being made in both the legal and medical literature.[32] The depth of interest in alternative methods of dealing with the malpractice problem is explained by the apparent dissatisfaction of all affected parties with the current litigation system.[33] Already an impressive number of local medical and bar associations, some invoking the services of the American Arbitration Association, have devised and implemented a variety of "screening plans" which draw on the principle of arbitration in an effort to identify, and expedite settlement of, meritorious claims.[34] Since these informal plans operate with varying degrees of authority and limited powers of compulsion,[35] they offer at best a partial release for the pressures of malpractice litigation. To the extent that the screening panel idea in actual operation departs widely from conventional arbitration, the value of such plans is to be found in the functions of discovery and mediation they undoubtedly perform.[36]

So long as medical services, current or prospective, are secured by private contract, the bargain may of course include a clause which calls for arbitration of controversies arising from the relationship. There exists no doctrine of public policy or rule of law which precludes employment of arbitration in the area of medical services. Indeed, with the coming of the legislative era of arbitration, the earlier hostile posture of the courts in general has changed dramatically. Today judges are not reluctant to find in arbitration statutes a compelling expression of policy favoring arbitration of disputes.[37] This friendly judicial reception has, in turn, spurred expansion of the device of arbitration to vast and diverse subject matters,[38] including the ordinary transactions of medical entities.[39]

With respect to contracts for medical services, a prestigious California decision, *Doyle v. Giuliucci*,[40] announces without qualification that arbitration is an acceptable forum for the settlement of disputes. And recent activities of the American Arbitration Association make clear that that professional body views the arbitral technique as indispensable to the effective delivery of medical care and health services.[41]

Though it is possible to contract for malpractice arbitration on an individual patient-physician basis, in advance of treatment, there is little evidence available that such a practice is widespread. The absence of evidence of ad hoc arbitration between patient and doctor may simply be the result of inadequate gathering and dissemination of information. Perhaps it is explained in part by a failure to reduce the patient agreement to writing, it being customary to imply such contracts from the transaction and the relationship of the parties. In addition to the failure to utilize any writing at all, the decisions reinforce the common view that physicians are inclined to rely on general or "blanket" consent forms which often prove inadequate in light of subsequent events.[42]

Even where medical services are rendered pursuant to a written consent form, inclusion of an arbitration clause is likely to be infrequent until such time as standardized medical forms are redrawn. In that connection, it is surely instructive that the most recent battery of consent forms sponsored by the Law Department of the American Medical Association fail to even mention arbitration.[43] Taking the litigated cases as a further guide to industry practice, there is practically no indication that the arbitration alternative is being offered to the casual contractor of medical or hospital services. But it is interesting to observe that at least in one instance where patients were asked by their physician to agree to arbitrate future malpractice claims, almost all patients complied with the request.[44]

There are, however, at least two patterns of provision for arbitration emerging in the malpractice context. One is anchored in the subscriber agreement for pre-paid family health care. The earliest such group medical program making use of arbitration, that of the closed panel Ross-Loos Medical Group of Los Angeles,[45] requires a subscriber to execute a lengthy contract, including the following clause:

> In the event of any controversy between the subscribing group and subscriber or dependent, or the heirs at law or personal representative of the subscriber or dependent, as the case may be, and Ross-Loos, when involving a claim in tort, contract or otherwise, the same shall be settled by arbitration.[46]

It should be noted that this arbitration contract is not limited to claims of malpractice; it embraces all disputes arising between patient and the medical personnel of the Ross-Loos group. Another contractual plan has recently adopted an arbitration clause which aims more directly at the malpractice problem. The Kaiser Foundation Health Care Plan in 1971 amended its Medical and Hospital Service Agreement to require binding arbitration in the event a claimant, "on account of death or bodily injury arising out of the rendition or failure to render services. . . ," asserts "any claim arising from the violation of a legal duty incident" to the agreement.[47]

A second developing approach to formal agreement to arbitrate malpractice is identifiable by an least two characteristics: the contracting process is hospital-based and speaks to current, not future, services. The plan which is now attracting nationwide attention was launched in 1969 at nine southern California hospitals, a joint undertaking of the California Hospital Association and the California Medical Association in cooperation with the American Arbitration Association.[48] The novel and distinguishing feature of the plan is that an arbitration agreement is made a part of the Conditions of Admission form executed by a patient at the time of hospital admission. The form itself reveals an unusually high degree of sensitivity to the problems of securing a contract, enforceable in court, which replaces litigation with arbitration. The latter is not obligatory under the admission contract; arbitration is optional in the sense that one of the parties must elect subsequently to initiate it in order to trigger that part of the contract. Moreover, the patient by written directive may opt against the arbitration alternative either at the time of admission or within 30 days of hospital discharge. The broad clause in use by the California pilot project reads as follows:

> 6. Arbitration Option: Any legal claim or civil action in connection with this hospitalization, by or against hospital or its employees or any doctor of medicine agreeing in writing to be bound by this provision, shall be settled by arbitration at the option of any party bound by this document in accordance with the Commercial Arbitration Rules of the American Arbitration Association and with the Hospital Association Regulations of the California Hospital Association (copies available at hospital admission office), unless the admitting physician has not agreed in writing to be bound by this provision, or unless patient or undersigned initials below or sends written notification to the conttary to the hospital within thirty (30) days of the date of patient discharge.

> If patient, or undersigned, does not agree to the 'Arbitration Option,' then he will initial here.[49]

If widespread arbitration is to occur between physicians and patient, it may well be that the impetus will come mainly from malpractice insurers who offer liability policies requiring a physician to contract for the sale of medical services on the basis of a standardized arbitration clause supplied by the insurer. Assuming the arbitration feature enables an insurer to provide malpractice protection at a reduced premium, the appeal of such policies to the medical profession is obvious. Thus, there would seem to be a relationship between the forms of liability insurance available to physicians and the incidence of arbitration between patient and physician.

An example of an insurance industry approach designed to increase arbitration of medical disputes is C.I.E. Plan III, currently sold to physicians by the Casualty Indemnity Exchange Company. Among other things, a physician applying for C.I.E. Plan III agrees to obtain arbitration agreements from specified percentages of his patients and, in the process, the physician undertakes to use "only that specific Arbitration Agreement Language provided by" the insurer.[50]

The physician-patient contract prescribed by C.I.E. Plan III raises some peculiar risks of unenforceability of the arbitral term. To begin with, the relation between the malpractice insurer and the insured physician adds, in theory at least, a new dimension to the agreement process by which a patient consents to arbitration. The issue, simply put, is whether the structure of the physician-patient bargaining process is affected significantly by the contractual leverage the insurer enjoys with respect to the physician. To the extent that insurance costs more favorable to the physician are expressly conditioned upon success in securing the prescribed contract from the patient, it is conceivable that this pressure will be reflected in the physician's dealings with his patients. Accordingly, there exists the danger of an appearance of overreaching when the availability of medical services is associated with a standardized form uniformly required among physicians in circumstances suggestive of disparity of bargaining power.[51]

The sponsors of C.I.E. Plan III anticipate some of these problems by explicit qualification of the duty to obtain arbitration agreements in specified situations, such as medical emergencies or the rendering of services to infants or incompetents.[52] One might fairly ask whether such limited contractual guidance adequately informs the physicians of the importance of marketing practices with respect to agreements to arbitrate medical disputes.[53] Having provided an incentive for the acquisition of patient agreements to arbitrate, it would seem the insurer ought not rely solely on physician self-interest to produce agreements enforceable in court. For example, the insured physician presumably understands that an arbitration agreement secured as a *condition* of the performance of services is inherently suspect. Yet the contract with the insurer does not oblige the physician to refrain from such bargaining techniques. Nor does it impose upon the physician any affirmative obligation of disclosure of the arbitral term.

Apart from its broader implications for bargaining context, the physician-patient contract called for by C.I.E. Plan III invites at least two observations relating to enforceability. Though appropriately entitled "Treatment and Arbitration Agreement,"[54] the sparse language of the agreement understates the sense of the arbitration undertaking asked of the patient. As noted elsewhere in this paper,[55] the inclusion of an arbitration term in a medical bargain involves special problems of knowledgeable assent, particularly where a general arbitration clause is placed in a full-page agreement that purports to cover the entire relationship of the parties.

A more serious problem exists because of the following provision in the C.I.E. Plan III agreement: "The PATIENT may withdraw from this agreement within 30 days from the above date by notification of his intent to do so to the ATTENDING PHYSICIAN by registered mail." First, a possible ambiguity exists respecting the reference point of the 30 day clause. Presumably the "above date" means the date of execution of the treatment form, which date is to be indicated in a space provided at the top right of the form. It is possible, however, to read "above date" to mean the "15 day clause" which appears in the same paragraph and serves as a cut-off time for the parties to appoint arbitrators after a demand for arbitration has been made. The practical difference between these two readings is obvious. If the latter interpretation is given effect, the patient's power of termination continues even beyond the demand for arbitration. Though this is apparently not the intended meaning of the 30 day clause, the question ought to be put to rest by improved drafting.

Secondly, the C.I.E. Plan III termination clause is significant because it is not limited to the arbitration clause, but rather extends to the entire agreement ("The PATIENT may withdraw from this agreement..."). Undoubtedly the patient withdrawal power represents an attempt to respond to the sensitive issue of arbitral consent in the medical bargain. Perhaps the idea originates in the option provision of the admissions form used in the California hospital project. Like that provision, the C.I.E. clause performs essentially a "cooling off" function. But whatever its source or motivation, the power of termination causes the entire contract to fall if exercised within the prescribed period.[56] This is a somewhat curious result in light of the "treatment" portion (first paragraph) of the contract. Not only does the treatment paragraph impose certain obligations upon the patient, but it purports to contract for the protection of certain interests of the physician, namely, a disclaimer of warranties and a standard of professional competence. Should the patient properly cancel under the clause, the patient-physician relationship depends on concepts of implied and quasi contract.

It therefore appears that the insurer is prepared to have the insured physician forfeit any advantages of the express contract on the assumption that the "cooling off" period guarantees an enforceable arbitration agreement. This suggests that the sponsors of C.I.E. Plan III have determined that the physician-patient contract is useful only to the extent it operates as an arbitration agreement.

Assuming the principal objective of the patient contract is to secure an arbitration clause enforceable in court, realization of that objective is endangered by the form of the 30 day withdrawal privilege. The doctrinal issue of contract presented is one of "mutuality of obligation." Surely the arbitral undertaking is not enforceable against the patient during the 30 day period. The critical question is whether a claim of lack of mutuality offers much prospect of success once 30 days have passed without withdrawal. As a matter of legal doctrine, the modern authorities indicate that the mutuality defect is eliminated with the expiration of the cancellation period.[57] Yet courts motivated to deny contract enforcement for reasons of essential fairness, or bargain disruption, or for whatever non-doctrinal reason, might well seize upon the once present mutuality defect as a ground for decision. The point is simply that the wide scope of the patient's option seems to attract difficulties that are not inevitable in accomplishing the objectives of the medical entity. Such difficulties, and the risks they entail, can be easily diminished by limiting the scope of the withdrawal power to the arbitration clause.

A common objective of the various contractual approaches noted above is to unburden medical services not yet rendered from the costs and delays of the litigation process.[58] The achievement of that goal depends in the first instance upon the enforceability of the contract to arbitrate. Whether consent to arbitration is sought in an application for health insurance against the future, or in a hospital admission or physician consent form tendered at the time a patient requests services, the central legal problem is whether a particular agreement will in fact be found to be mutually binding upon the contracting parties. The balance of this paper will adddress that question in the context of forms of agreement presently in use.

III. Formation of the Arbitration Agreement - Capacity of Parties

In light of the special considerations which inhere in the medical context, it seems in order to include some brief words about the application of the traditional law of contractual capacity to malpractice arbitration. The capacity question is particularly relevant to agreements to arbitrate medical disputes involving two classes of persons: infants and those under physical or mental disability.

The first thing to be noted is that assumptions about voluntary and intentional assent which underlay the entire system of contract are of course fully operative in the limited area here under consideration. Hence, whether or not an arbitration clause is in issue, the practical effect of incompetency by reason of infancy or mental defect is to create a power to avoid legal relations created by contract. While total incapacity ordinarily prevents the formation of a contract, partial incapacity will often render a contract voidable at the election of, or in behalf of, a party under disability.[59]

The question whether an infant must honor an agreement to arbitrate malpractice will arise frequently in an indirect and circuitous manner. Regardless of whether the basic contract is a continuing one for family health care, or one for immediate medical or hospital services, the infant, though an intended beneficiary, most likely is not a party to it. The power of a parent to contract for binding arbitration of a dependent's malpractice claim is therefore vulnerable to attack on the ground of the infant's customary power of disaffirmance.[60] In addressing this situation in 1965, the California Supreme Court in *Doyle v. Giuliucci*[61] established both authoritative precedent and a telling climate of analysis.

The *Doyle* court had little difficulty binding a dependent infant to the arbitration term of a health care contract executed by his parent. Looking to the various components of the statutory scheme, the court refused to imply a power of disaffirmance from the language of the state's general arbitration act. Nor was legislative confirmation of the standard doctrine of avoidance of infants' contracts deemed applicable to contracts of which the infant is not a party.[62] What emerges from the California court's handling of the legislative product is a rationale grounded primarily in policy considerations of practical content. Since an infant could disaffirm his own medical contract under state law, the court speculated that medical entities will be persuaded to contract exclusively with adults. Thus parents must possess authority to contract in behalf of minors if the latter group is to be "assured the benefits of group medical service."[63]

Moreover, if infants are afforded an opportunity to disaffirm the arbitration obligation, it must follow that the health care industry will look to non-arbitral processes for the disposition of infants' claims. The net result, in the judgment of the *Doyle* court, is that infants are "effectively denied the benefits of arbitration," a disputes forum which adequately safeguards the rights of infants.[64]

Even a grudging reading of *Doyle v. Giuliucci* supports the belief that sensible medical bargains for arbitration will receive sympathetic enforcement at the hands of the courts. But in attempting to define the limits of the strengthened position of malpractice arbitration resulting from *Doyle*, it is nevertheless important to identify some distinguishing features of that decision. For example, it is worth remembering that *Doyle* was decided in the absence of a statute dealing explicitly with the arbitration of infants' rights. In some states, including New York, a remnant of the disaffirmance power has been extended statutorily to arbitrations involving infants.[65] Decisions applying such provisions indicate that the courts will exercise caution when asked to impose arbitration upon a resisting infant.[66] Yet in the area of family health care, it is likely that the *Doyle* result would prevail even in New York because of case law which limits the infants' arbitration act to "party" contracts.[67]

Secondly, a critical step in the *Doyle* line of reasoning is the assumption that an infant can usually disaffirm his contract for medical services. Since as of this writing no other court has faced squarely a *Doyle*-type question, the local law of voidable contractual duties is of major importance. To the extent that a state may deny the power of avoidance of certain infant transactions, which many have done by legislation,[68] the case for binding an infant to another's contract in an unspecified subject matter area may be less compelling, though surely the negative inference argument has only slight force. In that connection, it can be argued convincingly that the *Doyle* arbitration results is in fact consistent with the present trend to restrict, by means of a restitution obligation, an infant's power of disaffirmance.[69] As the *Doyle* rationale makes clear, the arbitration duty is considerably less onerous than many of the obligations, procedural and substantive, imposed on infants by law independently of contract.[70]

Turning to contractual mental capacity, again there exist no legal doctrines of competency peculiar to medical bargains which include a clause for malpractice arbitration. But because the impetus for, and objective of, the principal contract is medical attention, it is arguable that the rate of incidence of the capacity question may be higher than in other types of commercial bargains. The case law, at least, does not as yet support such an assertion.[71] In any event, the medical bargain struck in a hospital admissions room is particularly vulnerable to a claim of lack of capacity, as is to a lesser degree the consent form executed for the occasional services of a physician. In the absence of independent evidence of overreaching, mental illness or defect would seem to be of still lesser moment in the case of an applicant for future health care insurance or group medical service.

Whatever the pattern of circumstances giving rise to contract, the threshold legal problem is always the same: to articulate and apply the governing standard that measures competency. It is accepted without question that substantial public policy mandates judicial examination of the acts of an alleged mentally incompetent.[72] Bargains policed on the claim of incapacity require reconciliation of two competing policies. The security of transactions must be protected by giving effect to justifiable expectations. Conversely, it is necessary to protect persons unable to protect themselves against imposition.[73] Until recent times, it was customary in civil cases to balance these conflicting policies under the so-called "cognitive test" of mental competency. That test, simply stated, inquires whether the mind of a person is so "affected as to render him wholly and absolutely incompetent to comprehend and understand the nature of the transaction."[74]

Because the cognitive approach fails to take into account the many types and degrees of mental incompetency, such as inability to control conduct even though cognitive ability is unimpaired, modern law has moved to supplement the cognitive test with one which emphasizes the fairness of the transaction.[75] The *Restatement (Second) of Contracts* attempts to distil from the authorities some working principles than gauge the impact of incompetency upon the particular transaction. Briefly summarized, mental illness or defect constitutes a ground for contractual avoidance where (1) a person is unable to reasonably understand the nature and consequences of the transaction, unless the contract is made on fair terms and the other party has no reason to know of the incompetency, in which event the power of avoidance is permitted only on equitable terms; or (2) even though understanding is complete, a person lacks normal capacity to control his acts and the other party has reason to know of this condition.[76] A New York decision that has attracted much attention leaves little doubt that the *Restatement's* more liberal standard of competency can be expected to receive an affirmative judicial reception.[77]

It is arguable, nevertheless, that this broader formulation will in fact alter the results in particular cases, though it will undoubtedly facilitate explanation of results. The point is simply that one need examine only a few of the decisions in which a claim of incompetency is raised to be impressed that this corner of the law has always been heavily "result oriented."[78] Even the older, more restrictive rules produced acceptable results when indications of unfairness or overreaching were sufficiently strong.[79]

To the extent that it is true that the capacity question is fundamentally one of total impact in a given case, there are some lessons with special relevance to agreements to arbitrate malpractice. An observation both obvious and compelling is that a malpractice claimant resisting arbitration on capacity grounds is rarely able to demonstrate the consequences flowing from the specific clause he seeks to upset. He will not have transferred assets at a bargain price, or foregone economically valuable rights at another's urging. Consequently, avoidance of contract does not enable a court to proceed directly to the restoration of an economic status quo. The issues of malpractice liability and damages must still be heard and determined. The immediate dispute is limited to the forum for the hearing; the initial battle decides only the arena for waging the war on the merits. A disposition of that preliminary matter unfavorable to the injured claimant, then, does not have the effect of leaving him in an irrevocably prejudicial position.

Viewed in this light, the impact on rights of an incompetency defense to arbitration is more procedural than substantive.[80] The immediate pecuniary benefit to the alleged incompetent realized by contract avoidance is not easily identified. Assuming there is absent a disparity of values in the original bargain, as well as abuses of the bargaining process, it would appear difficult to make out a case of incapacity sufficiently convincing to avoid the limited arbitration obligation.[81] If over-all fairness of the transaction is today an explicit and controlling consideration in close cases, which is said to be so,[82] the current popularity of the arbitral system is a factor of some weight. The commercial nature of the particular transaction is usually examined by the courts in the capacity cases.[83] As already observed, arbitration of medical malpractice has been held to be a reasonable alternative to litigation.[84] For purposes of testing irrational or unintelligent behavior, it is not likely that the courts would regard an arbitration clause as a wide departure from normal conduct. A medical business bargain which includes such a clause is far from bizarre.

Lastly, it is necessary to add that the incapacity question seldom arises in isolation. Indeed, lack of capacity nearly always appears in combination with other grounds of contract avoidance, such as duress, undue influence, fraud, confidential or fiduciary relation, or gross inadequacy of consideration.[85] To the extent that these various concepts merge and overlap in application, they perform supportive functions which supply a basis for judicial control of the bargaining process, a subject to which we now turn.

IV. Formation of the Arbitration Agreement - Supervision of the Bargaining Process

At the moment a party asks a court to compel or stay arbitration, both the prinicipal contract and the arbitration clause therein become the central focus of attention. The parties being unable to carry through their transaction aided solely by private processes, the legal effect of the arbitral undertaking is determined in court as a matter of contractual enforcement. That undertaking may be denied for any number of reasons addressed to the language of the parties' written expression of intention, as well as the assent process that produced formal agreement. Whatever the specific defenses tendered, a denial of the obligation to arbitrate aims at neutralizing either the arbitration clause or the entire contract.

Despite statutory regulation, judicial proceedings to enforce arbitration agreements are often confused and little understood affairs. This is so because substantive law issues are enmeshed inextricably with problems of division of labor between court and arbitrator. In fact, because of the conventional view that commercial arbitrators are not bound to apply strict rules of law or evidence,[86] the question of who decides enforcement issues, court or arbitrator, is in many respects more significant than speculations about applicable law. For this reason, the discussion that follows will include a consideration of the general matter of judicial involvement in the arbitration process.

A. FAILURE TO REACH AGREEMENT

Court ordered arbitration being possible only pursuant to agreement, it is of course elementary that an enforcement proceeding presupposes the existence of a valid contract. The typical modern arbitration act affects the question of existence of an arbitration agreement in several ways. As already observed, an otherwise enforceable agreement is no longer revocable prior to award. The defense of lack of agreement is permitted—indeed, required in many states[87]—to be raised at the outset of the proceeding, in which event a summary procedure for disposition is supplied by most statutes.[88] Statutory specification of the defense of nonexistence of agreement serves the dual function of controlling judicial intervention. It is commonly said that the sole issue open to the court on a preliminary motion to compel or stay arbitration is whether there exists an agreement to arbitrate.[89] Accordingly, once the court disposes of the question, its power over the controversy is cut off substantially. It must either order or deny arbitration without regard to the merits of the case.[90]

As applied in the field of medical agreements, doctrines of contract assent do not present many of the problems normally associated with formation of the arbitration agreement. The so-called "battle of the forms" that attends commercial contracts for the sale of goods will occur rarely.[91] The agreement for medical services is not arrived at by an exchange of mailed, unresponsive standard forms, aggravated by following confirmations or memoranda. Nor will the search for assent to malpractice arbitration require exploration of the problems of "incorporation by reference" that arise from trade association and industry rules and practices.[92] On the contrary, the medical bargain is not yet institutionalized for the most part. It results most often from a unitary, documentary exchange, whether the format be an application for group coverage, a consent to immediate services or a hospital admission document.

The essential problem of contract formation, then, is likely to be raised by the assertion of the resisting party that he did not intend to agree to the arbitration clause and was unaware of its existence. Such claims rest on the notion of knowing or informed consent, and draw into consideration such factors as size of print and internal positioning of the arbitration provision. It can be expected that the usual legal doctrines will be applied. But the familiar rule that a contracting party is bound by a writing to which he signifies general assent, whether or not he read or understood specific terms,[93] must be reconciled with the institutional character of the medical services' contract. In that connection, the qualifications on the general rule, most of which evolve from the disclosure requirement, are particularly relevant here.

Putting aside for the moment a major consideration of bargaining power and context—matters that go primarily to the issue of fundamental fairness—the medical arbitration forms noted earlier[94] are always subject to the claim of insufficient knowledge of the term. Even a fair and otherwise enforceable term may not be enforceable if unknown by the other party. As with most standardized form contracts, the likelihood of success of a claim of unknown terms is diminished by the use of printed language which itself indicates, by means of size or calibration, an intention to disclose, rather than mislead. The Uniform Commercial Code test of a "conspicuous" writing is surely usable analogically to the fine print problem in medical agreements.[95] Since the objective is to create the appearance of having made a genuine attempt to inform, the risk of unenforceability can be reduced by modest improvements in the drafting and positioning of arbitration clauses. For example, the exclusionary feature of the admissions form used in the California pilot project requests, and allows space for, the exercise of choice by the patient. The mere fact of choice is highly relevant on the question of whether a normally constituted person is alerted to the arbitration alternative. In addition, that form wisely permits a subsequent period of time for study of the option. Once the case is made that a term is known, it can be expected that the claim of lack of understanding will lose much of its appeal in court.[96]

Moreover, while the customary "broad" clause (e.g., "all disputes arising out of this agreement") carries special meaning in arbitration circles, there is relatively little experience with such clauses in medical services' agreements. For that reason alone, greater specificity of claims for personal injury connected with the contractual treatment may well be in order. If the intent of the medical entity is really to insure arbitration, not litigation, the addition of carefully selected, explanatory language can hardly be deemed objectionable.

But more important than the rules of construction is the approach a court will use to the disclosure problem in a particular business setting. Unless the courts are sufficiently persuaded that malpractice arbitration agreements are fundamentally fair and not unexpectedly made a part of the medical contract, the rules of interpretation are of little use in predicting enforceability. As medical agreements call increasingly for arbitration of malpractice, it is likely that the judicial attitude will parallel that exhibited in such other fields as insurance. Standardized contractual language will be read in such a way as to give effect to the normal expectations of the non-professional.[97]

To the extent it is deemed wise policy to allow a malpractice claimant to waive access to the courts, the latter will be inclined to find knowledgeable assent to the arbitration clause. Since that term does not disclaim rights attached substantively to the claim, or release meritorious defenses prospectively, it may well come to be regarded as consistent with the essential terms of the medical transaction.[98] If so, invocation of arbitration by a medical entity does not unreasonably disappoint expectations. Such judgments will, of course, depend in large part on the manner in which the principal contract is marketed, as well as its actual operation in a given case.

The point is mainly that ordinary assent principles are shaped by the business needs of the area of activity in which they find application. But in addition to medical context, the institution of arbitration must itself be taken into account on the question of contract formation. It is necessary to observe that, as a general matter, an undertaking to arbitrate will not lightly be imputed by the courts. In fact, despite a heavy policy preference today for arbitration, it is still common practice to apply to arbitration clauses a more rigorous test of agreement.[99] Such undertakings, in the language of one court, require a higher "threshold of clarity."[100] In an effort to police the requirement of clear and precise language, the courts repeat the warning that the consensual basis of arbitration must be "unextended and unenlarged either by construction or by implication."[101]

Viewed in context, such admonitions seek to express a rough judicial notion of clarity of choice. Coupled with the standard of explicit intention is the corollary legal view that an arbitration clause is a "material" term for many purposes, one of which being contract formation.[102] It has been observed elsewhere that these views operate against the grain of current efforts to expand liability in the overall commercial field.[103] This conclusion may be unwarranted. The tésts of clarity and materiality, in actual practice, seem to operate primarily as devices for resolving doubts against arbitration in situations where a contractual basis is lacking for other reasons, usually because the bargaining process is untidy and fragmentary.[104] It is unlikely these tests will often affect results in single document transactions involving a broad arbitration clause.

B. THE SCOPE OF AGREEMENT – ARBITRABILITY

Assuming an arbitration agreement is established, arbitration may still be resisted in court on the ground the controversy in question does not come within the terms of the contractual undertaking. Such an assertion presents the so-called issue of "arbitrability," about which there continues to exist a good deal of confusion and disagreement. The controlling question of whether in fact a specific dispute is arbitrable under the agreement is at all times accompanied by the inseparable question of who decides arbitrability.

In order to make sense out of the divergent and irreconcilable case law, one must reduce the arbitrability problem to simple terms. When private contract breaks down, an aggrieved party can secure a compulsory order to arbitrate only from a court. Thus, by reason of its position in the ordering of things, a court is given the first opportunity to decide whether arbitration shall occur at all, and if so, what tasks are to be left to the arbitrator. But given the consensual character of arbitration, a court must find a contractual basis for its order directing use of that system of dispute settlements. Since the parties are free to contract for as much or as little arbitration as they desire, the court is called upon to determine the extent to which they exercised that power in a given contract. Thus, the arbitrability issue emerges as one essentially of giving effect to the parties' expressed intention about the use of arbitration.

The problem, of course, is that the parties rarely detail the precise issues they agree to arbitrate. Rather, because of the widespread use of general or broad clauses, the usualy case involves a sweeping generalization: "any claim or controversy arising out of this agreement" is to be submitted to arbitration. Once having accepted the contractual premises of the arbitral system, it followed as matter of course that a court would not compel a party to arbitrate who had not agreed to do so.[105] The performance of this protective function had led naturally to the widely held assumption that, at least in commercial arbitration, the courts generally determine arbitrability in the first instance.[106] Since the existence of any contract at all is a question for the courts, so must the courts retain the issue of contractual submission of a specific dispute.[107]

Nevertheless, many courts have appreciated the difficulties in avoiding the merits of the dispute in the process of defining the scope of the submission agreement. Since the latter question inevitably requires an examination of the totality of the transaction—the contract as well as all surrounding circumstances—there is always present a considerable risk that a court will substitute its judgment for that which the parties expected from the arbitrator. Viewed in this light, there exists a major issue of policy beneath the surface of the arbitrability concept. The courts must be prepared to intervene to protect parties who have not voluntarily consented to forego the judicial system in favor of an arbitral one. At the same time, the system of arbitration must be effectuated most of the time if its advantages are to be widely realized and the parties' choice of a speedy, inexpensive remedy is to be honored. The latter objective presumes infrequent judicial intervention.

The competing policies have been balanced in the field of labor arbitration by a general approach to the effect that, once it is shown that the parties have in fact executed a broad arbitration agreement and have not expressly excluded the dispute in question from its operation, contractual questions on which the parties disagree are left to the arbitrator.[108] The policy of deference to arbitration is reinforced in the labor cases by a rule of construction which resolves doubts about contract scope in favor of coverage.[109] Yet the heavy presumption which limits the judicial role and expands that of the arbitrator has not been transported intact from labor to commercial arbitration, largely because practical differences between the two fields, identified and emphasized by as high a court as the United States Supreme Court,[110] are still the subject of much debate with respect to the interchangeability of legal doctrine.[111]

To the extent the Federal courts adjudicate a medical services' agreement under the auspices of the Federal Act, as might conceivably occur in the case of a broadly based group medical insurance plan, the handling of the arbitrability question will closely approximate practice in labor arbitration. The Federal courts have been instructed by the Supreme Court to pass solely on issues relating to the "making and performance" of the agreement to arbitrate a commercial dispute, sending most questions of validity, interpretation and enforceability to the arbitrator.[112] There is growing evidence that the Federal courts, in ascertaining whether the party seeking arbitration is making a claim which on its fact is governed by the contract, will apply the resumption of coverage.[113] It appears that the only express qualification on the presumption is that it is inoperative with respect to a "frivolous or patently baseless" claim.[114]

In contrast, arbitrability practices in the respective states vary considerably, as do articulations of the proper judicial function. Undoubtedly the Federal decisions are having an impact on state commercial arbitration decisions. California case law has for the most part embraced the full Federal rationale on the question of arbitrability.[115] In New York, with few deviations, it has long been clear that once it is determined the parties have agreed broadly to arbitrate, "it is for the arbitrators to decide what the agreement means. . . "[116] This policy is generally understood to forbid judicial interference with any dispute "within the compass of" or "logically connected with" the agreement.[117] To be sure, courts in other jurisdictions are considerably less inclined to so limit judicial involvement in arbitration. Two states having identical statutes, the Uniform Arbitration Act, provide a dramatic example of disparity in judicial approach. The controlling Minnesota decision holds that where the parties disagree as to the scope of the arbitration clause, and the issue of contractual intention is reasonably debatable, the arbitrability question is to be initially determined by the arbitrator.[118] The Illinois courts, on the other hand, reject such a "free-wheeling" policy on statutory as well as policy grounds.[119] The scope of the arbitral agreement in Illinois is a matter for the courts, not the arbitrator,[120]

Whatever a state's position on the arbitrability question, there is no reason to believe it would be altered with respect to medical malpractice agreements. But in view of the fact that arbitration clauses in use medically are broad ones, a few observations appear in order. Neither the Ross-Loos nor the California hospital clauses mention malpractice. The former purports to include "any controversy . . ., when involving a claim in tort, contract or otherwise;" the latter by its terms reaches "any legal claim or civil action."[121] Even though such clauses fairly and reasonably cover malpractice,[122] it is possible that a court in ascertaining the intention of the parties would conclude otherwise.

For example, the relationship of an injury tortious in nature to the contractual theory of liability may confuse the theoretical basis for the proceeding, including the arbitrability question.[123] In addition, a court may well be receptive to the claim that the patient reasonably understood and intended the language of the arbitration clause to mean such things as financial responsibility for hospital bills or physician's fees. It must be remembered that judicial conclusions about a patient's intention will be colored by the manner in which the contract is presented in the overall bargaining context. The natural trauma which attends medical care or confinement cannot be ignored contractually. Given the infrequency of medical malpractice arbitration, and the scant judicial authorities respecting such clauses, a court might readily conclude that the reasonable layman did not express an arbitral intention about medical misconduct in the words "controversy," "civil action," or "legal claim," even though qualified by the description "tort" or "contract."[124]

Such grounds for denial of arbitration may easily be erased by enlarging the language of the present clauses, or by drafting a clause limited to malpractice claims. The reason given for declining the latter alternative in the case of the California hospital project is at best puzzling,[125] and fails to offset the gains to be realized by only a slight effort at increased communication. Even in states most likely to send claims to arbitration, a failure to specify subject matter in the arbitration clause occasionally results in a bar to that form of remedy.[126]

C. CHALLENGES TO THE VALIDITY OF AGREEMENT

As observed above, modern arbitration statutes recognize the role of ordinary contract defenses.[127] Perhaps the largest grouping of defenses is to be found under the label of "voidable" contracts, where the practical effect of an aggrieved party's election to challenged liability is that of contract rescission. Typical examples are where a party is an infant, or is induced by mistake, duress or fraud. Contract doctrine also marks off a category of "unenforceable" contracts, distinguished by rules under which the duty of performance does not depend solely on a party's election; rather, enforcement is barred as a matter of remedy. Some contracts, for example, are unenforceable because of statutes of limitation, or a statute of frauds, or because they arise out of an illegal bargain. In addition, since the indispensable elements of a binding contract are mutual assent ("meeting of the minds") and consideration, defenses to arbitration may rest on alleged deficiencies in these requirements. Regardless of how the alleged invalidating cause is raised procedurally, its purpose is to test the validity of a contract.[128]

A defense of invalidity having been raised, the issue of current interest and activity is whether the power of decision rests with the court or with the arbitrator. Court referral of such matters to arbitration is important not only because of the selection and application of legal rules, but because of the limited judicial review of arbitration awards normally available.[129]

Once again the Federal law of commercial arbitration is a dominant force, largely because of its adherence to the theory that an arbitration clause is separable from the principal contract of which it is formally a part. The "separability" doctrine[130] has received the widest circulation and articulation in cases involving the defense of fraud in the inducement, the definitive decision being *Robert Lawrence Co., Inc. v. Devonshire Fabrics, Inc.*[131] Briefly stated, that litigation establishes the proposition that a general attack on a contract for fraudulent inducement is to be decided by the arbitrator, under the arbitration provision as a severable part of the contract, and that only where the claim of fraud in the inducement goes specifically to the arbitration clause itself should it be adjudicated by the court.

The analysis leading to such a result contains several noteworthy elements. First, the critical and overriding factor is the language of the arbitration clause. The parties are of course free to contract to arbitrate most questions that arise out of their relationship, including whether one of them was induced by fraud to undertake the transaction. Accordingly, when that defense is raised in a proceeding to compel arbitration, the court proceeds to the usual examination of the parties' arbitral intent. If the arbitration clause is a broad or general one, the search for intention is indeed brief; the prevailing view is that a broad clause is deemed to encompass arbitration of most claims of defective contract.[132]

Secondly, the separability concept requires an explanation of how an arbitration clause can survive a claim that the entire contract, including that very provision, is in fact invalid. The ready answer given by the courts is that mutual promises to arbitrate supply consideration for each other, thereby permitting the arbitral undertaking to stand independently of the balance of the main contract.[133] It follows that unless a party alleges specifically that the defect goes to the arbitration clause itself, which is not often likely to be the case,[134] there is no way to bar arbitration of the claim of invalidity under the separability analysis. The contractual power of the arbitrator, conferred by the arbitration clause, does not fall with the rest of the contract.

The Supreme Court, in the 1967 commercial arbitration case of *Prima Paint Corp. v. Flood & Conklin Mfg., Co.*,[135] faced squarely the issue of whether a claim of fraud in the inducement of the entire contract is to be resolved by the court, or whether the matter is to be referred to an arbitrator. The Court chose to rest its holding on a statutory analysis which was charted earlier by the lower Federal courts. Its reading of the Federal statutory scheme supplies persuasive guidance for the application of any modern state arbitration act.

A party seeking to compel compliance with an arbitration agreement finds a remedy in Section 4 of the Federal Act. Under the wording of that section, a court is instructed to order arbitration to proceed once it is satisfied that "the making of the agreement for arbitration or the failure to comply therewith is not in issue."[136] In the view of the Court, this language does not contemplate judicial consideration of claims of fraud in the inducement of the contract generally. Rather, the authority of a court is limited exclusively to issues which go to the "making" of the agreement to arbitrate.[137] Thus, only if the claim of fraud in the inducement is directed to the arbitration clause itself may the court exercise decisional power.[138]

Perhaps more significant than the separability result of *Prima Paint* is the policy choice that persuaded the Court to narrow the role of a court *vis-a-vis* the arbitrator. After that decision there can be little doubt that Federal law has been fashioned with a single objective in mind: to facilitate the arbitration procedure. To that end, it was necessary that the Court minimize the expense and delay of extended judicial proceedings preliminary to arbitration. An important labor arbitration decision handed down during the last term of the Supreme Court confirms the bias for an unobstructed system of arbitration.[139]

Litigation since *Prima Paint* reinforces the obvious thrust of that decision, namely, that the Federal rationale of the fraud cases must necessarily apply to the full spectrum of contract avoidance grounds. In recent years defenses ranging from laches[140] and waiver of arbitral rights[141] to material breach[142] have been referred to commercial arbitrators. The general directions having been set, the practical question is whether the narrowing of the role of the courts has a reasoned stopping point. Apart from defenses grounded in various claims of public policy and illegality,[143] the answer appears to lie in the principal contract of the parties. Courts are cautioned to honor evidence that the parties intended to reserve specific issues for judicial resolution.[144] Evidence of intention to withhold from arbitration has, for example, been found in conditions precedent to contract obligation, though the reason given by some courts for finding express conditions non-arbitrable is somewhat puzzling.[145]

At least two statutory provisions are relevant to the Federal definition of the respective roles of court and arbitrator. One is Section 4 of the Federal Act, which *Prima Paint* read as limiting the courts to issues going to the "making" of an agreement to arbitrate. With respect to the keystone word "making," it appears the only defenses which "unmake" an arbitration clause are mutual rescission of that clause or its challenge on the usual grounds of contract avoidance—e.g., mistake, fraud or duress.[146] Thus, to say, for instance, that a defense such as waiver "un-makes" the arbitration agreement is viewed as stretching the language of Section 4 beyond tolerable limits.[147]

Secondly, the issue of what constitutes the "making" or "unmaking" of an arbitration agreement for purposes of Section 4 of the Federal Act is informed by the meaning of the word "revocation" in Section 2, the general validation provision which adds a "savings" caluse for such grounds of invalidation "as exist at law or in equity for the revocation of any contract."[148] The question is whether judicially cognizant issues are expanded when "revocation" is considered in the context of the statutory test of "making." The answer is apparently a negative one. Revocation in contract law most accurately describes the power to control an offer or option. As used in Section 2, the term surely is intended to refer to the remedial process of "rescission," a concept commonly used to describe the consequences of avoidance for reasons such as fraud, mistake or duress, or to depict the destruction of a contract by mutual assent. This line of reasoning, to be sure, comes full circle. It leads back to the conclusion that only mutual rescission and the standard grounds of contract avoidance frame issues of "making."[149] This position is defended, nevertheless, as effectuating the statutory scheme, since the presumed intent of the Section 2 "savings" clause was to make arbitration agreements as enforceable as, but no more so, than any other contract.[150]

There is good reason for dwelling at some length on the Federal law of commercial arbitration crystallized by the landmark opinion in *Prima Paint.* Though not directly concerned with enforceability, that decision, in the course of addressing the issue of who decides whether the main contract is defective, in fact establishes a broad principle of enforceability when it recognizes the separable, independent standing of the parties' promise to arbitrate. Regardless of the fate of the main contract, the arbitration clause survives as a viable obligation, Indeed, its continuing vitality is a matter of national substantive law irrespective of a state rule that finds such a view unacceptable.[151] But, in attempting to evaluate the status of state law, the preemptive effect of the Federal separability rule on the states—an issue not reached in *Prima Paint*[152]—is a question of lesser importance than that of whether the states will voluntarily receive the Federal rule with its principal effect of transferring contractual disagreements to arbitrators.

It is somewhat surprising to observe that only on rare occasions have either the rule or consequences of separability surfaced in the state decisions. A partial explanation lies in the recent vintage of legislation making arbitration agreements enforceable at all. Given that threshold obstacle to enforcement, it can hardly be expected that the states would often reach second level issues. But in spite of scant authority that appears to express disapproval of the notion of a separable obligation to arbitrate,[153] there is every reason to believe that the states will move in the direction of increased submission of contract disputes to arbitration, whether or not the separability rationale is offered up as the basis for decision.

To begin with, thirty states now have modern arbitration acts with provisions paralleling closely those of the Federal Act. *Prima Paint*, from the perspective of precedent, must be viewed as possessing immensely compelling force, both as an expression of statutory construction and overall arbitration policy. The states have not erected, either by statute or decisional law, a fixed rule or policy of non-separability.[154] With court dockets universally congested, the arbitral procedure offers an inviting avenue for the release of pressures of litigation. Once it is understood fully that contracting parties have opted for arbitration of legal issues as a matter of voluntary choice, which freedom *Prima Paint* confirms without qualification, the state courts will be less inclined to fear imposition in relegating parties to a non-judicial forum.

Events in New York, the state with the most advanced law of commercial arbitration, lend support to the claim of increased workloads for arbitrators. The decision that is the focus of growth for New York case law, as well as that of other states,[155] is *Exercycle Corporation* v. *Maratta,*[156] where, in a dispute concerning the employment status of an employee, a stay of arbitration was attempted on the ground of lack of mutuality of obligation, an objection addressed to the enforceability of the agreement as a whole. The Court of Appeals directed arbitration, holding that whether the contract lacked mutuality was a question for the arbitrator to decide. Its stated rationale would seem to leave little room for exceptions to a general policy of judicial non-interference:

> "Once it is ascertained that the parties broadly agreed to arbitrate a dispute 'arising out of or in connection with' the agreement, it is for the arbitrators to decide what the agreement means and to enforce it according to the rules of law which they deem appropriate in the circumstances.

> . . . [w]here parties enter into an agreement and . . . promise that any dispute arising out of or in connection with it shall be settled by arbitration, any controversy which arises . . . and *is within the compass of the provision* must go to arbitration. (Emphasis added.)"[157]

Yet *Exercycle*, in deference to the felt need to reconcile earlier precedents, preserved for court adjudication four categories of issues: a court may enjoin arbitration where (1) the contract is voidable, as for fraud or duress, or (2) lacking a bona fide dispute, the asserted claim is frivolous, or (3) the performance in dispute is prohibited by statute, or (4) a condition precedent to arbitration, contractual or statutory, is unfulfilled.[158] Given the result and rationale of *Exercycle* it is questionable whether each of these exceptions can withstand close analysis.[159] For instance, it makes little sense to say that arbitrators are to decide contract formation issues, which is what *Exercycle* does respecting the consideration problem of mutuality, but not such issues as fraud or duress that render a contract voidable.[160] Furthermore, the decision is not even internally consistent on the contract formation category; the failure of effective assent occasioned by lack of mutuality is not easily distinguished from such a failure resulting from unfulfilled conditions. A recent New York decision can be read as conceding as much.[161]

Without engaging in close case parsing, it can be said with some assurance that the *Exercycle* restrictions on arbitrability do not detract from a general climate favorable to arbitration of issues of contract validity. The language of the opinion to the effect that a defense of fraud is not for the arbitrator is of course dictum. Rhetoric aside, the court did in fact order arbitration in the face of a claim that the underlying contract was fatally void. It is not surprising, then, that some subsequent decisions seem to regard the restrictive portion of the *Exercycle* opinion as no longer reliable.[162]

But aside from technical considerations, the *Exercycle* decision radiates broad implications. Though it stays clear of the separability rule, thereby appearing to support the assumption that contracts with arbitration clauses are indivisible under New York law, the *Exercycle* result verges on acceptance of the theory of separability. In making the very existence of an operative principal contract a question for the arbitrator, the authority of the arbitrator can only exist independently of the main contract. Stated differently, to say that arbitration must decide the validity of a contract at all is but one side of a single coin; the other side must be that the court, once having found execution of a contract with a broad clause, is prepared to leave most questions of validity and enforceability to arbitration.[163] If so, about all that is left of major importance is the issue of validity and coverage of the *arbitration agreement.*

This analysis of course accomplishes the Federal rule of separability of arbitration clauses. But since the New York arbitration statute is the model for the Federal Act, as well as the acts of other states, similarity of results should be neither unexpected nor unwelcome.[164] Thus, the Federal pattern is likely to shape the course of state decisional law with respect to claims of contract invalidity. Indeed, some Federal courts are prepared to presume that states having not yet dealt with the separability rule would in fact apply it were the decision in the hands of the state court.[165]

Accordingly, when arbitration of medical malpractice is challenged in a state court becuase of fraudulent inducement, duress, lack of informed assent or other grounds going to contract validity, it will be necessary to sort out a number of issues at an early stage of the proceeding. A defense addressed specifically to the arbitration provision, as opposed to the contract as a whole, will enhance the chances that a court will reserve the question for decision. On the other hand, a general assault on the entire contract may well place the parties before an arbitrator. In view of the peculiar features of the medical services' relationship that distinguish it from the ordinary commercial transaction, particularly the underlying factor of personal injury, one might reasonably project a relatively high rate of success in making the alleged claim reach the arbitration clause itself. If so, a patient resisting arbitration is before a court and must fall back on standard doctrines of the substantive law of contract avoidance.

As court litigation of the arbitral terms in medical agreements increases in volume, some measure of predictability will undoubtedly develop.[166] At the moment there is simply no real basis in the case law for such predictions. As will be noted shortly, there are reasons to question a wholesale transfer of the full law of commercial arbitration to the realm of medical malpractice bargains.

The forum for decision of the claim of invalidity will be determined, as observed, primarily on the basis of the language of the arbitration clause. If broad clauses continue to be used in medical agreements, without exclusionary language, the customary interpretation of such clauses can be expected. Accordingly, all disputes, whether arising from contractual breach or tortious conduct, will be heard by the arbitrator. To the extent a court chooses to "interpret" a medical arbitration clause, even though it is one in the usualy broad form, it will select from the various canons of contract construction, taking into account the nature of the subject matter of the transaction and general arbitration policy.[167] Supposedly the basic rules of construction and interpretation of contracts in general apply to arbitration agreements.[168]

A final problem of contract invalidity relates to the form of relief sought by the claimant in arbitration. Since a medical entity is surely interested only in specific performance of the agreement to arbitrate, and a patient interested primarily in defeating that forum in order to get his damage claim before a court, it is necessary to note only that conceptual difficulties flowing from the nature of the rescission remedy are no longer of vital concern. The lessening of such problems is one of the by-products of the separable arbitration agreement view.[169]

V. The Integrity of the Arbitration Process - Special Problems of Standardized Contracts of Adhesion

All that has been said thus far underscores a fundamental assumption of the system of arbitration, namely, that it will be called upon to supply an alternative to court litigation solely by reason of an exercise of choice by private parties. Modern arbitration statutes having made machinery available, the decision to use that machinery must still be the result of agreement. Indeed the statutory mechanism is not applicable unless the parties have executed a "voluntary" written agreement to arbitrate.[170] Thus it is not enough that a party seeking to compel arbitration offers in court contractual language that shows an intention to arbitrate rather than litigate. The court will examine that expression of intention with a view to determining whether it is genuine.

It had already been noted that the first prerequisite of genuinely voluntary agreement to arbitration is some minimum sense of "awareness" of the term. Where a standardized form contract is used, which is the format in the vast bulk of contracts today, it is common knowledge that the non-sponsoring party assents to terms neither read nor understood. Unless unknown terms exceed the range of reasonable expectation, the approach of the law is to regard an adherent to a standard form contract to have bound himself in detail by blanket assent.[171] Nevertheless, the application of these ordinary contract principles to arbitration clauses in general, and to medical arbitration agreements in particular, raises some troublesome issues not found in other classes of transactions or types of contracts.

The price of arbitration is forfeiture of the right to a day in court on the merits of a claim. Though the judiciary has come to appreciate the many benefits of arbitration, and to generally favor its use to settle disputes, the case law makes clear that not even the courts are inclined to lightly find that a party has surrendered a judicial determination. This attitude in large part reflects considerations of public policy that cluster about arbitration agreements. The primary purpose of modern statutes being to validate *agreements* as a first step to effectuation of arbitration, the courts are aware that the legislature has expressed in unmistakable terms a public policy that anchors arbitration in consent. Some states have taken extra precautions to insure clarity of choice respecting arbitration. Rhode Island, for example, has a unique statutory provision requiring an arbitration agreement to be "clearly written and expressed and contained in a separate paragraph placed immediately before the testimonium clause or the signatures of the parties."[172] Texas goes so far as to approve an arbitration agreement only if it is "concluded upon the advice of counsel to both parties as evidenced by counsel's signatures thereto. . . "[173] More universally, the widespread statutory requirement of a writing and the traditional distinction between present and future disputes suggest more than a casual interest in assuring a knowledgeable waiver of access to the courts.

Given the distinctive nature of the medical services transaction, the use of a standardized form of agreement with a broad arbitration clause runs the risk of failure to satisfy the policy of awareness of the substituted forum. The arbitration provision, viewed from the perspective of the patient, is indeed subsidiary to the primary exchange of medical services for an undertaking of payment.[174] Absent some guidance by the medical entity, the patient has little reason to know anything at all about the system of arbitration, let along that the tendered document serves an arbitral purpose. Nor should the medical entity ordinarily expect a patient to read or even to understand a broad arbitration clause. A court, in these circumstances, is faced with the question of whether the patient is nevertheless bound by the term in accordance with conventional legal analysis, having had reason to know that the writing was used to embody contract terms. In resolving that question, a consideration peculiar to all executory arbitration agreements may well be weighted heavily in the medical context. Not only is the resisting party (presumably the patient) claiming lack of knowledge of the arbitration term, but he asks not to be prevented from litigating a controversy that was also unknown and non-existent at the time of contracting.[175] Viewed in this light, the knowledge factor is doubled in its impact.

A. THE FORM CONTRACT AND DISPARITY IN BARGAINING POWER

The difficulty of predicting the outcome of litigation over unknown terms is increased because that issue rarely is presented in isolation from a range of legal doctrines that attend the bargaining process. In fact, the courts today are engaged in a broadly based review of contracts with a view to isolating unfair terms that result from disruption in bargaining. The approach is illustrated in *Hellenic Lines, Ltd.* v. *Louis Dreyfus Corp.*,[176] a leading case involving the claim of duress in obtaining an agreement to arbitrate. After examination of various attempts to identify the substantive elements of duress, the court was able to arrive at only a generalized statement of a legal standard.[177] But apart from definition of controlling rule, the real focus of attention was the bargaining process. The court's reading of a close factual record appeared to leave the claim of impaired bargaining power roughly in balance. Ultimately, judgment was rested on the observation that the contesting parties were both large companies, with substantially equal bargaining positions. It therefore ill behooved the objecting party "to argue that it was the victim of serious economic duress in the classic legal sense."[178]

To the extent a medical entity makes regular use of a standardized form of agreement, offering it to patients on essentially a "take it or leave it" basis, the arbitration clause presents a "contract of adhesion" problem.[179] Since standardization eliminates bargaining over the details of individual transactions, the obvious danger is that contract terms are imposed by one party upon another. Indeed, the essence of an adhesion contract is that bargaining position and leverage enable one party "to select and control risks assumed under the contract."[180]

Any discussion of the relevance of bargaining power to the enforceability of arbitration clauses must take into account an obscure statement appearing in a footnote to the Supreme Court's opinion in *Prima Paint Corp.* v. *Flood and Conklin Mfg. Co.*[181] It will be recalled that the Court, while addressing the question of who should decide a claim of fraud in the inducement of the entire contract, emphasized that the use of a broad clause manifests the parties' intention to arbitrate all contractual disagreements. At the same time, it observed that the Court of Appeals had in the past carefully evaluated evidence of intention to withhold matters from arbitration, adding the following footnote comment:

> "We note that categories of contracts otherwise within the Arbitration Act but in which one of the parties characteristically has little bargaining power are expressly excluded from the reach of the Act." See § 1.[182]

Though dictum, this comment unmistakably places the Court on record as believing that certain classes of contracts—i.e., those "in which one of the parties characteristically has little bargaining power"—are not enforceable under the Federal Act. The problem is to identify such contracts. The Court's reference to Section 1 of the Act, in which the meaning of "maritime transaction" and "commerce" is defined, coupled with its language about express exclusion "from the reach of the Act," is apparently intended to connect its bargaining power statement with the statutory exclusions of Section 1:" . . . contracts of employment of seamen, railroad employees, or any other class of workers engaged in . . . interstate commerce."[183] If this is a correct reading of the Court's meaning, the bargaining power statement does little more than suggest that private employment contracts, as distinguished from commercial transactions having a commerce impact, are to be more closely policed for essential fairness because of a history of frequent disparity in economic power of the contracting parties.

Still, a more comprehensive reading is also possible. At an earlier point in the *Prima Paint* opinion the Court quotes the "savings" clause of Section 2 of the Act, the basic validation section indispensable to enforcement of executory arbitration agreements. More important, it attaches to that quotation a footnote reference not to Section 2, but to the defined terms of Section 1 and without mention of the exclusions of that section.[184] Accordingly, the Court's subsequent reference to Section 1 in the context of its bargaining power statement may be read as a recognition that arbitration clauses are to be policed, under the Section 2 saving clause, for unequal bargaining power the same as any other contract. Given the saving clause—written agreements to arbitrate are enforceable, "save upon such grounds as exist at law or in equity for the revocation of any contract"—this reading of the Court's purpose would amount to a restatement of the obvious: an arbitration term that is unfairly imposed by reason of disparity in bargaining power is as much a ground for "revocation" as is any other ordinary contract defense.

Whatever the Court's intended meaning, it spoke in the context of defending a referral of the fraudulent inducement issue to arbitration. Perhaps it meant only to suggest that since the classes of contracts actionable under the Federal Act will normally involve parties of equal bargaining status, there is no good reason to deny an arbitrator the power of decision. If so, this proposition at the very least hints that the courts should withhold arbitration where a substantial question of bargaining power does exist. Such a view is not easily squared with the rule of *Prima Paint* to the effect that claims of invalidity are reserved for court adjudication only when addressed to the arbitration clause itself.

Aside from the question of the types of contracts excluded from the Federal Act, with respect to which judicial interpretations have not as yet provided a list, *Prima Paint* sets a tone and establishes a climate for approaching adhesion problems in the arbitral setting. It reflects a general view that the enforceability of promises to arbitrate depends on "arms length negotiations" having preceded the bargain.[185] More important, the Supreme Court's attempt to distinguish certain types of contracts on the basis of relative bargaining strength suggests that arbitration agreements are to be examined from the perspective of *the relationship of the parties.* The significance of this is that arbitration contracts are brought within the conventional analysis of adhesion contracts, an analysis that finds obligation not solely in the consensual words or character of the contract, but in the status" relationship of the parties created by the standardized contract.[186] If this is indeed the case, arbitration agreements may well come to be marked off for the special scrutiny accorded such other types of contracts as insurance, retail sales, banking and small loans.

The general law of adhesion contracts makes clear that, with some variation depending on subject matter, standard terms imposed by one party are generally enforced. An unequal bargaining position, even that which results in the transfer of risks to the weaker party, does not alone invalidate contractual obligation; it is the beginning point for analysis. Hence it is not enough to merely point to a standardized contract and allege adhesion. In order to persuade a court to deny enforcement, an objecting party is usually required to show, from the language of the contract itself, substantially unequal, and therefore prejudicial, bargaining strength. Moreover, the contract must mirror the calculated design of the more powerful bargainer to meet its own needs and to offer only its terms to the weaker party.[187]

Assuming such a showing is made, the courts, motivated by considerations of fairness and the public interest, have access to various techniques for policing against one-sided contracts or terms. The rule of "construction against the drafting party" is commonly invoked in cases of standardized contracts or cases of imbalance in bargaining position.[188] An obligation of good faith and fair dealing in contract performance and enforcement is being imposed at an increasing pace.[189] And after many years of review of unfair terms by adverse construction and manipulation of related doctrines of contract, the courts now possess black letter authorization to effectuate the policy agains "unconscionable" contracts or terms.[190]

The fundamental approach to the standardized adhesion contract is, nevertheless, to ascertain the reasonable expectation of the forced adherent. The controlling test, the impetus for which is the disparate bargaining status of the parties, has been stated in clear terms by Professor Kessler:

> "In dealing with standardized contracts courts have to determine what the weaker contracting party could legitimately expect by way of services according to the enterpriser's 'calling,' and to what extent the stronger party disappointed reasonable expectations based on the typical life situation."[191]

Of present concern are the questions whether this analysis extends to the arbitration provision of a contract and, if so, what results are to be expected. Several decisions, mainly in California, suggest an affirmative answer to at least the first question.

One California court, assuming that the standardized employment contract before it "may well be one of adhesion," refused to declare that such contracts are beyond the coverage of the state's arbitration act.[192] In fact, the principal justification for the court's confirmation of an arbitration award in the face of a claim of adhesion was the favored position accorded arbitration by the legislature in adopting the very arbitration act in question. On a more recent occasion another California court was confronted with an attempt to invalidate an arbitration clause on the basis of the adhesion doctrine. Again assuming the contract was adhesory, and applying the standard test of reasonable expectations of the weaker party, the court could only conclude that "it is not shown that arbitration would be contrary to the reasonable expectations of any party or that any loss or unfair imposition would result."[193] These two cases involved, respectively, arbitration disputes relating to an employee discharge and the forfeiture of profit sharing rights under a non-competition covenant.

A more complex litigation of the arbitration obligation, arising out of a construction contract dispute, employed the theory of adhesion to strike down a cross-country provision in an arbitration clause.[194] The construction project being situated entirely in California, as well as the dispute, the court refused to approve a term calling for arbitration to take place in New Jersey. The point of the case, for present purposes, is that the court was prepared to deny effect to a "fine print" arbitration clause which operated to give a distinct advantage to one party.[195] The clause in question was "quite a weapon" in that it "discouraged" a party "with possibly legitimate claims from usging such claims because of the expense involved."[196] To enforce such an advantage would, in the judgment of the court, obstruct the policy of the arbitration act to expedite and facilitate the settlement of disputes.

B. THE ADHESION QUESTION IN THE MEDICAL SETTING

Applying the lessons of the arbitration cases specifically to agreements to arbitrate medical malpractice, resolution of the adhesion problem again turns on the overriding policy question. Because the widespread use of a standardized form means that the medical patient seldom bargains with the medical entity over arbitral terms, a "take it or leave it" atmosphere is apparent.[197] Nor is the patient, on his own initiative, likely to raise questions about the import of the arbitration term. Accordingly, the policy issue is framed in terms of whether the waiver of the right to a court determination of malpractice can be justified on the basis of a patient's blanket assent, in advance of treatment, to a unilaterally drafted form a term of which obliges the patient to arbitrate. As the policy issue comes to the courts it is translated into a seemingly uncomplicated legal question of whether, in light of the requirement of a *voluntary* agreement to arbitrate in lieu of a judicial determination, there is a basis for enforcement of the clause. The legal authorities, reinforced by practical considerations, suggest that a case can be made for allowing the medical industry this power of contract.

Enough has been said already to indicate the almost irresistible pull of dispute settlement by means of arbitration, and that the courts are oriented in the direction of giving effect to contractual intention to arbitrate if for no other reason than to relieve congested dockets.[198] A broad arbitration clause in a standard form medical services' contract has been enforced in a California malpractice situation without even mention of the adhesion problem.[199] Assuming the conventional expectations test is applied widely to medical arbitration clauses, it is essential to underscore the point that the primary reason for application of such a test is that the disadvantaged bargaining party is harmed or unfairly overreached. The factor of harm or prejudice as a practical matter measures the range of reasonable expectation induced by a standardized contract.[200] So unless it can be said that a medical arbitration term operates in a bizarre or oppressive manner, it is difficult to see that it exceeds the expectations of the average patient who accepts it.

The consequence of closing the doors of the courts, as earlier observed, is not to subtract from the substance of the liability claim or eliminate a central purpose of the transaction.[201] Moreover, given the faster, less expensive mode of arbitration, it can indeed be argued that enforcement of the clause operates to the distinct advantage of the medical patient.[202] The force of the contention will of course be determined on the basis of experience with the relative number and size of successful arbitration awards in relation to patterns of court recoveries. There is presently little evidence for assessing the impact of arbitration on malpractice claimants, though medical proponents openly confess an objective of reduction in amounts paid to patients.[203]

Furthermore, the absence of reliable evidence that malpractice arbitration operates to the advantage of medical entities, with corresponding disadvantage to the patient, is a matter which cuts two ways. It is surely relevant to a court's attempt to effectuate reasonable expectations consistent with a standardized medical contract. Absent terms unreasonably favorable to the stronger party, there is less reason to regard the bargaining process as suspect.[204] On the other hand, in applying normal tests of assent to standardized agreements, there is less basis for a court to draw the inference that the stronger party had reason to know that the arbitration term was contrary to the adhering party's interests or assumptions.[205] Ultimately, the degree of freedom of contract allowed medical entities with respect to arbitration clauses will be affected by marketing techniques that either fortify or disclaim the "take it or leave it" appearance of a particular transaction. Reasonable disclosure or explanation, coupled with at least an opportunity to read the term, will go far to minimize claims of bargaining disadvantage. In addition, sensitive administration of the arbitration clause after a claim surfaces can be expected to influence judicial attitudes about enforcement in general.[206]

One final consideration remains, having particular relevance to hospital based contracts. There is case law that includes hospital-patient contracts in the vague category of "contracts affected with a public interest." One of the leading decisions, *Tunkl* v. *Regents of the University of California*,[207] holds that a provision releasing a hospital from liability for future negligence, imposed on a patient as a contractual condition of hospital admission, is invalid as against public policy because of its adverse impact on the public interest. In light of the widely held view that an exculpatory contract is valid only if the public interest is not involved,[208] the *Tunkl* court was compelled to answer the question whether a contract between a hospital and an entering patient is affected with a public interest. In concluding that it is,[209] the California Supreme Court invoked the concept of "status" relationship to differentiate a hospital from an individual contracting party.[210] Moreover, though the case did not involve any issue of arbitration, the court used sweeping language that conceivably extends to problems here under discussion:

> "In insisting that the patient accept the provision of waiver in the contract, the hospital certainly exercises a decisive advantage in bargaining. The would-be patient is in no position to reject the preferred agreement to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract. As a result, we cannot but conclude that the instant agreement manifested the characteristics of the so-called adhesion contract. Finally, when the patient signed the contract, he completely placed himself in the control of the hospital; he subjected himself to the risk of its carelessness."[211]

The draftsman of any medical arbitration clause, whether it be hospital or physician related, cannot safely ignore this language. *Tunkl* does involve questions of bargaining power and fundamental fairness in the context of a standardized term of a medical contract. Undoubtedly the arbitration clause in the California hospital project was drafted in direct response to the risks of enforceability exposed by *Tunkl.* Yet the rhetoric of that opinion must be tempered by a recognition that the clause there in question is a far cry from one specifying a procedure for settling later disputes. Clauses providing for compulsory assumption of the risk of another's negligence occupy a special place in the policing of bargains.[212] Indeed, it is the very act of surrender of valuable substantive rights that serves to confirm a breakdown in the bargaining process, thereby inviting intervention of the public interest notion.[213]

When it is seen that the public interest concept is primarily a rule of legal effect, resting more on special considerations of public policy than on contractual intention, the modest impact on rights occasioned by enforcement of a bargain for arbitration should be adequately distinguished.

VI. Conclusion

Malpractice arbitration is but a single application of a far reaching arbitral system. Since the arbitration agreement is a province of contract, the courts can be expected to respond to problems of construction by invoking rules and principles of promissory liability that, on the basis of considerable experience, have been shaped to the particular needs of arbitration in general. If true agreement is expressed in the medical contract, there is no basis for denying enforcement. Yet once widespread use of malpractice arbitration develops, the incidence of enforcement will depend primarily on whether the arbitration clause is viewed as representing actual agreement or a unilateral decision by the medical industry. The latter image can be avoided only by meaningful drafting and sensible marketing techniques. Above all else, industry practices must create not only the impression that malpractice arbitration furthers the interests of the medical patient, but that the patient himself thinks so as evidenced by a real choice to waive access to the courts.

Footnotes

1. While it is customary to classify arbitration in two general categories, labor and commercial, these major classifications do not describe fully the many varieties of disputes for which the technique of arbitration is used today. See generally M. Domke, The Law and Practice of Commercial Arbitration §§ 13.01-13.10 (1968) (here-

inafter cited as Domke). The label "commercial arbitration" is sufficiently broad to embrace the arbitral process in the context of medical malpractice. For a laundry list of the often-stated advantages of the arbitration procedure, see Coulson, Texas Arbitration–Modern Machinery Standing Idle, 25 Sw. L. J. 290-92 (1971).

2. The decisions are collected in Annot., 135 A.L.R. 79 (1941). Presumably for common law attitude toward the executory arbitration agreement continues in the absence of statutory modification. See Green v. Wolff, 140 Mont. 413, 372 P.2d 427 (1962). But see Park Constr. Co. v. Indep. School Dist., 299 Minn. 182, 296 N.W. 475 (1941).

3. The distinction between executory agreements and submissions to arbitration of existing controversies is of long standing. See Myers v. Jenkins, 63 Ohio St. 101, 57 N.E. 1089 (1900).

4. The historical basis for the "ouster of jurisdiction" concept is critically evaluated in 6A A. Corbin, Contracts § 1433 (1963). That concept is even today not totally without supporters. Heisner v. Jones, 184 Neb. 602, 169 N.W.2d 606 (1969); Lerma v. Allstate Ins. Co., 301 F. Supp. 361 (N.D. Ind. 1968).

5. If the parties elected to proceed with arbitration in accordance with the agreement, the resulting award was usually enforced by the courts. E.g., Morrison Department Store Co. v. Lewis, 96 W.Va. 277, 122 S.E. 747 (1924). This result lends support to the modern view that, despite language to the contrary in the decisions, agreements to arbitrate future disputes were not "void" at common law in the sense of illegality; rather, though it was permissible to enter into such agreements, they were judicially unenforceable.

6. See, e.g., Rubena Products Co., Inc. v. Watson's Quality Turkey Products, Inc., 242 A.2d 609 (D.C. Ct. App. 1968).

7. A state-by-state grouping and summary, with statutory references, is undertaken in Aksen, Resolving Construction Contract Disputes Through Arbitration, 23 Arb. J. 141, 149-51 (1969). Briefly summarized, modern arbitration legislation first appeared in the form of the New York Arbitration Act of 1920, which act served as a model for other states and the federal government. The United States Arbitration Act followed in 1925, providing for arbitration solely in contracts involving maritime transactions and contracts evidencing transactions involving interstate or foreign commerce. See 9 U.S.C.A. § § 1-14 (1970). As early as 1924 the Commissioners on Uniform State Laws drafted a model act; their efforts culminated in the Uniform Arbitration Act of 1955. 9 Uniform Laws Ann. 78-85 (1957) A number of states have enacted the Uniform Act in its entirety or with minor changes; others have departed from the model although incorporating the essential elements of a modern arbitration statute. See generally Domke, § § 4.01-.03; M. Bernstein, Private Dispute Settlement: Cases and Materials on Arbitration 45-46 (1968).

The states with some version of modern arbitration legislation are: Alaska, Arizona, Arkansas, California, Connecticut, Florida, Hawaii, Illinois, Indiana, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Virginia, Washington, Wisconsin, and Wyoming.

8. For example, Section 1 of the Uniform Arbitration Act declares: "[A] provision in a written contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract." 9 Uniform Laws Ann. 78 (1957).

It should be added that some state courts, in the absence of a modern statutory provision, have declared valid and enforceable future arbitration clauses. E.g., Exell v. Rocky Mt. Bean & Elevator Co., 76 Colo. 409, 232 P. 680 (1925); United Ass'n of Journeymen Union v. Stine, 76 Nev. 189, 351 P.2d 965 (1960).

9. The many variations in the statutes of these states are described in Aksen, supra note 7, at 151-55.

10. E.g., Latter v. Holsum Bread Co., 108 Utah 364, 160 P.2d 421 (1945).

11. The states of Oklahoma and Vermont are included within this category. Cf., Bernhardt v. Polygraphic Co. of America, 350 U.S. 198 (1956).

12. See King v. Beale, 198 Va. 802, 96 S.E.2d 765 (1957); Andrews v. Jordan, 205 N.C. 618, 172 S.E. 319 (1934). At least one state, Washington, has eliminated common law arbitration by court decision. Puget Sound Bridge & Dredging Co. v. Lake Washington Shipyards, 1 Wash.2d 401, 96 P.2d 257 (1939). As to differences between statutory and common law arbitration, see Exell v. Rocky Mountain Bean & Elevator Co., 76 Colo. 409, 232 P. 680 (1925).

13. E.g., La Vale Plaza, Inc. v. R.S. Noonan, Inc., 378 F.2d 569 (3d Cir. 1967); Alexander v. Fletcher, 206 Ark. 906, 175 S.W.2d 199 (1943); Vitaphone Corp. v. Electrical Research Products, 19 Del. Ch. 247, 166 A. 255 (1933). See generally Sturges and Reckson, Common Law and Statutory Arbitration: Problems Arising from their Coexistence, 46 Minn. L. Rev. 819 (1962).

14. 9 U.S.C.A. § 2 (1970). "Commerce" is defined in Section 1 of the Federal Act to exclude contracts of employment of seamen, railroad employees and other classes of workers engaged in foreign or interstate commerce. 9 U.S.C.A § 1 (1970).

15. In Prima Paint Corp. v. Flood & Conklin Mfg. Co., 388 U.S. 395 (1967), the court found an agreement relating to the facilitation of the purchase and re-establishment of a paint business to evidence a transaction in interstate commerce. It rejected the contention that the Federal Act is limited to contracts between merchants for the interstate shipment of goods; rather, the test is one of conduct having a relationship to interstate commerce. 388 U.S. at 401-02. See generally Note, Scope of the United States Arbitration Act in Commercial Arbitration: Problems in Federalism, 58 Nw. U. L. Rev. 468 (1963).

16. In addition to questions about the constitutional basis of federal arbitration law, a reconciliation of the Federal Act with state law necessarily raises choice of law and preemption problems. See Note, Federal Arbitration Act and Application of the "Separability Doctrine" in Federal Courts, 1968 Duke L. J. 588.

17. The question of whether contractual issues of enforceability are to be resolved by an arbitrator, or judicially determined, will be treated in a subsequent portion of this paper.

18. Bernhardt v. Polygraphic Company of America, 350 U.S. 198 (1956).

19. 271 F.2d 402 (2d Cir. 1959).

20. 271 F.2d at 409.

21. The court stopped short of extension of the Federal Act to the states, though it established unequivocally that that Act is substantive and not merely procedural. 388 U.S. at 403, 406.

22. A leading illustration is Metro Industrial Painting Corp. v. Terminal Constr. Co., 287 F.2d 382 (2d Cir. 1961), cert. denied 368 U.S. 817 (1961). Cf. Hellenic Lines, Ltd. v. Louis Dreyfus Corp., 372 F.2d 753, 756 (2d Cir. 1967). The relevant cases are collected and discussed in Note, Commercial Arbitration in Federal Courts, 20 Vand. L. Rev. 607 (1967). At least this much is clear: an arbitration clause otherwise subject to state law is governed by the Federal Act when a party invokes Federal court processes.

23. See Restatement (Second) of Conflict of Laws § § 332-332b, 354h (Tent. Draft No. 6, 1960); Necchi Sewing Mach. Sales Corp. v. Carl, 260 F. Supp. 665 (S.D. N.Y. 1966); Lummus Co. v. Commonwealth Oil Ref. Co., 280 F.2d 915 (1st Cir. 1960), cert. denied 364 U.S. 911 (1960); Ross v. Twentieth Century Fox Film Corp., 236 F.2d 632 (9th Cir. 1956).

24. Younker Bros., Inc. v. Standard Constr. Co., 241 F. Supp. 17 (S.D. Iowa 1965); Kentucky River Mills v. Jackson, 206 F.2d 111 (6th Cir. 1953).

25. On the problems of removal and preemption, see Sears, Roebuck & Co. v. Glenwall Co., 325 F. Supp. 86 (S.D. N.Y. 1970); Note, Federal Arbitration Act and Application of the "Separability Doctrine" in Federal Courts, 1968 Duke L. J. 588, 607-14; Annot., 63 A.L.R.2d 1356 (1959); Domke § 4.03.

26. A "modern" arbitration act is said to qualify for such a description by containing the following provisions: (1) irrevoc-

ability of agreements to arbitrate future disputes; (2) judicial power to compel a party to arbitrate at the request of the other; (3) judicial power to stay, pending arbitration, a court action instituted in violation of an arbitration agreement; (4) court authority to appoint arbitrators and fill vacancies when the parties fail to so provide; (5) restrictions on judicial power to review awards of arbitrators; and (6) specification of the grounds for attack of awards. Domke § 4.01.

27. Section 2 of the Uniform Arbitration Act directs a court to order arbitration unless the existence of the agreement is placed in issue, in which event "the court shall proceed summarily to the determination of the issue raised and shall order arbitration if found for the moving party..." A court may not refuse an order for arbitration "on the ground that the claim ... lacks merit ... or because any fault or grounds for the claim" have not been shown. See Ill. Rev. Stat. ch. 10, § 102 (1969).

28. See generally Domke § § 6.01-103

29. E.g., Fisser v. Int'l Bank, 282 F.2d 231 (2d Cir. 1960); Wm J. Burns Det. Agency, Inc. v. N. J. Guards Union, 64 N.J. Super. 301, 165 A.2d 844 (1960).

30. See Mendelson v. Shrager, 432 Pa. 383, 248 A.2d 235 (1968). Most modern arbitration acts state that an agreement to submit to arbitration is enforceable "save upon such grounds as exist at law or in equity for the revocation of any contract." E.g., Minn. Stat. Ann. § 572.08 (Supp. 1963): 9 U.S.C.A. § 2 (1970).

31. In addition, there is considerable judicial language to the effect that an arbitration statute is deemed a part of the contract to arbitrate, the same as though expressly incorporated therein. Flood v. Country Mutual Ins. Co., 232 N.E.2d 32, 35 (Ill. App. 1967).

32. E.g., Lillard, Arbitration of Medical Malpractice Claims, 26 Arb. J. 193 (1971); Averbach, Rx for Malpractice, 19 Cleve. St. L. Rev. 20 (1970); Ludlam and Hassard, Arbitration, 44 J.A.H.A 58 (1970); Note, Arbitration of Malpractice Claims, 28 Arizona Medicine 391 (1971); Note, Arbitration of Medical Liability, 211 J.A.M.A. 175 (1970).

33. The 1972 Annual Report to members of the American Arbitration Association summarizes that dissatisfaction as follows:

> [I]nsurance rates are constantly rising, and some insurance companies have discontinued the writing of malpractice policies altogether. Doctors and hospitals are unhappy because, among other reasons, they believe that some claims lacking merit are settled by insurance companies to avoid the cost of litigation. Moreover, they complain that the prospect of malpractice litigation is having an adverse effect on the quality of medical services. Attorneys for claimants and the patients themselves are dissatisfied with the present state of affairs because it is frequently difficult to obtain the expert medical witnesses necessary to sustain actions at law.

Arbitration News, No. 3, March-April 1972, at 4.

For conclusions resulting from a Senate inquiry into the increase in medical malpractice litigation, see Senate Subcomm. on Exec. Reorganization, Medical Malpractice: The Patient Versus the Physician, S. Res. 25, 91st Cong., 1st Sess., 1-13 (1969).

34. Procedures for submission of malpractice claims to screening panels exist in plans in effect in perhaps as many as 23 states. For detailed explanations of this use of a diluted version of the arbitration principle, see Lillard, supra note 32, at 199-07; Coulson, Should Medical Malpractice Claims Be Arbitrated?, Unpub. Memo., Am. Arbitration Ass'n. (Oct. 23, 1970); Note, Joint Screening Panels, 215 J.A.M.A. 1715 (1970).

35. The New Jersey Plan, anchored in a civil practice rule of the State Supreme Court, is distinguishable in that an agreement to submit a malpractice claim to a medical panel is specifically enforceable, and an adverse determination bars suit on the claim. See Grove v. Seltzer, 56 N.J. 321, 266 A.2d 301 (1970); Marsello v. Barnett, 50 N.J. 577, 236 A.2d 869 (1967).

The Columbus, Ohio Plan is representative of those administered by the American Arbitration Association. An arbitration panel of lawyers and physicians, appointed by the AAA from lists submitted by each group, decides, after an informal hearing, whether there is probable cause to believe that negligence exists and, if so, whether the claimant was injured. On finding for the claimant, the panel recommends settlement. If the matter is not settled, or the claimant wishes to press his claim in court, the medical society is obligated to furnish the names of two expert witnesses willing to testify for the claimant. If the panel finds against the claimant, his attorney is ordered to discontinue suit, which order is binding in accordance with an agreement filed upon initiation of the case. Coulson, supra note 34, at 8-9. It is reported that twelve claims have been disposed of during the first fifteen months of operation of the Columbus Plan. Arbitration News, No. 9, Nov. 1971, at 1.

Perhaps the most distinctive application of the screening panel idea is to be found in New Hampshire. Effective January 1, 1972, a statute of that state establishes a "hearing panel" procedure for the bringing of malpractice claims against lawyers and dentists, as well as doctors, in advance of the commencement of litigation. N.H. Rev. Stat. Ann. ch. 519-A: 1-10 (Supp. 1971). The plan, administered by clerks of the superior court, contemplates that each claim submitted shall be heard informally by a panel consisting of a judicial referee and a lay and a professional person. Rather elaborate procedures exist for party participation in the drawing of the lay and professional members from a standing panel. The composition of each three member panel varies with the profession of the defendant. In the case of a doctor, the judicial referee is joined by a layman and a doctor. Except for the judicial referee, who is presumably an official in the court system, panel members serve without compensation. See N.H. Rev. Stat. Ann. ch. 519-A:1,2 (Supp. 1971).

The New Hampshire approach is a far cry from conventional arbitration; indeed, it is little more than a mechanism for "testing" the merits of a claim in malpractice. A claimant's decision to submit to a hearing panel is entirely voluntary. Though the statute imposes mandatory *procedural* duties once a claim is filed with the court clerk, the question whether the claim can be withdrawn prior to the panel's decision is not answered explicitly by the statute. Moreover, the decision of the panel is binding only if both parties subsequently accept it in writing, in which event a decision for the claimant specifying the amount of recovery is given the effect of a judgment. If either or both parties reject the decision, the claimant is free to institute a lawsuit on his claim. No procedure for direct review of the decision of the hearing panel is provided. See N.H. Rev. Stat. Ann. ch. 519-A:4, 5 (Supp. 1971). A further departure from ordinary arbitration is to be seen in the statutory mandate that the "decision shall be in accordance with the law of New Hampshire as applicable to such cases in the judgment of the hearing panel ... " N.H. Rev. Stat. Ann. ch. 519-A:4 (Supp. 1971).

Lastly, it is worth noting that the New Hampshire statute is distinguishable from the screening panel concept in an important respect. Unlike most such devices, the New Hampshire approach does not attempt to facilitate eventual litigation by making expert medical testimony available to a malpractice plaintiff. The statute does, however, address the applicable standard of professional care or competence for purposes of the hearing panel proceeding, as well ad the relevance and weight of expert testimony in such a proceeding.

36. In testimony before the Secretary's Commission on Medical Malpractice, Department of Health, Education and Welfare, AAA Executive Vice President Robert Coulson has emphasized the mediation function arbitration plays in the early stages of a medical grievance. Arbitration News, No. 1, Jan. 1972, at 1.

In addition to the discouragement of baseless claims, a principal objective of most screening plans is to make expert witnesses available to meritorious claimants, thereby eliminating the so-called "conspiracy of silence." Averbach, supra note 32, at 31-32. See generally Note, Overcoming the "Conspiracy of Silence:" Statutory and Common Law Innovations, 45 Minn. L. Rev. 1019 (1961).

37. E.g., Gregg Kendall & Associates, Inc. v. Kauhi, 488 P.2d 136, 140 (Hawaii 1971): " . . . the proclaimed public policy of our legislature is to encourage arbitration as a means of settling differences and thereby avoid litigation." Judicial encouragement of arbitration is of course motivated primarily by crowded and congested court dockets. See Mendleson v. Shrager, 432 Pa. 383, 248 A.2d 235 (1968).

38. Special applications of the arbitration device are discussed in Domke § § 13.01-.10. Arbitration in the field of tort, often called "adjudicative claims arbitration," represents a fast growing area of activity. See S. Elliott, Arbitration–Materials and Cases 199-48 (1968). In fact, accident claims represent the largest single group of arbitrations administered by the regional offices of the AAA during 1971, 12,564 out of a total case load of 22,459. Arbitration News, No. 3, Mar.-April 1972, at 2.

39. See Astoria Medical Group v. Health Ins. Plan of Greater New York, 11 N.Y.2d 128, 182 N.E.2d 85 (1962); Straus v. North Hollywood Hospital, Inc., 150 Cal. App.2d 306, 309 P.2d 541 (1957).

40. 43 Cal. Rptr. 697, 62 Cal.2d 606, 401 P.2d 1 (1965).

41. In April of 1972 the AAA sponsored in New York a Conference on Dispute Settlement in the Health Field, a major portion of which focused upon innovations in the application of arbitration. Arbitration News, No. 5, June 1972, at 1, 4. Cf., Holley and Carlson, The Legal Context for the Development of Health Maintenance Organizations, 24 Stan. L. Rev. 644 (1972).

42. See, for example, Rogers v. Lumberman's Mut. Cas. Co., 119 So.2d 649 (La. 1960). Cf., Averbach, Rx for Malpractice, 19 Cleve. St. L. Rev. 20, 30, 34-36 (1970).

43. AMA Medicolegal Forms With Legal Analysis 33-44 (1961).

44. A noted urologist reports that only ten of 600-700 patients declined to agree to an arbitration clause when asked to do so. Arbitration News, No. 9, Nov. 1971, at 2.

45. The Ross-Loos group has over the years used various forms of agreement to "party appointed" arbitration. See, e.g., Spanach v. Superior Court of Los Angeles County, 43 P.2d 339 (Cal. App. 1935), writ denied 4 Cal.2d 447, 50 P.2d 444 (1935).

46, The provision appears in Coulson, Should Medical Malpractice Claims be Arbitrated?, Unpubl. Memo., Am. Arbitration Ass'n., at 11 (Oct. 23, 1970). Although the Ross-Loos contract specifies a method for initiating arbitration proceedings and party selection of arbitrators, the medical group is often agreeable to arbitration under the rules of the American Arbitration Association. See Doyle v. Giuliucci, 43 Cal. Rptr. 697, 62 Cal.2d 606, 401 P.2d 1 (1965).

47. The arbitration amendment reads in relevant part:

ARBITRATION OF CLAIMS

A. Initiating a Claim. Any claim arising from the violation of a legal duty incident to this Agreement shall be submitted to binding arbitration if the claim is asserted:
   (1) By a Member, or by a Member's heirs or personal representative ("Claimant"),
   (2) On account of death or bodily injury arising out of the rendition or failure to render services under this Agreement, irrespective of the legal theory upon which the claim is asserted,
   (3) For monetary damages exceeding the jurisdictional limit of the Small Claims Court,
   (4) Against one or more of the following ("Respondent"):
      a. Health Plan,
      b. Hospitals,
      c. Medical Group,
      d. Southern Permanente Services, Inc., or
      e. Any employee or partner of the foregoing. . .

1971 AMENDEMENT to Group Medical and Hospital Service Agreement, KAISER FOUNDATION HEALTH PLAN, INC., SOUTHERN CALIFORNIA REGION, GR.-M & HSA-71 (ARB), at 28. This plan appears to be hospital-based to some degree.

48. A thorough explanation of the mechanics and operation of the demonstration project appears in Ludlam and Hassard, Arbitration, 44 J.A.H.A 58 (1970).

49. Id., at 60. The arbitration clause is implemented by detailed Hospital Arbitration Regulations, drafted simultaneously with the admission form. Id., at 61-62. Since the contract refers to arbitration rules of an agency administering commercial arbitration, the California plan assumes the characteristics of so-called "institutional arbitration." See Domke § § 5.02-103

50. The application for C.I.E. Plan III reads as follows:

In making application for Medical-Professional Liability Insurance under the Casualty Indemnity Exchange, C.I.E. Plan III, I understand that said plan provides for arbitration of disputes between insured physicians and their patients and therefore agree to the following:

(1) I will obtain no arbitration agreement from any patient in any circumstance that constitutes an emergency. (2) In the event that a minor or incompetent patient requests my services, I will see that the arbitration agreement for that patient is signed by a parent or legal guardian of that patient. (3) I will obtain arbitration agreements from a minimum of 90% of all new patients requesting treatment commencing with inception of the cover, if issued. (4) I will, within the first year from inception of the cover for which application is made, obtain arbitration agreements from a minimum of 50% of all patients whom I treated prior to the inception of this cover and who return for treatment during that period. (5) I will, by the end of the second year from inception of the cover for which application is being made, obtain arbitration agreements from 85% of all patients whom I treated prior to the inception of the cover for which application is being made and who request treatment during that period. (6) I will use only that specific Arbitration Agreement Language provided by Casualty Indemnity Exchange as it may be amended from time to time by the Exchange. (7) I understand and agree that my records will be subject to audit without prior notice at the Company's discretion with regard to any of the above considerations. (8) I understand further that should I fail in the above covenants that this program will be converted, retroactive to inception, to another Casualty Indemnity Exchange Medical-Professional Liability plan of my choosing, and that any deposit differential due (on a retrospective basis) will be payable immediately. Should any deposit differential due not be paid within 10 days of submission of the bill to the insured under Provision 8 of this agreement, then the policy for the alternate plan, whichever it may be, will be issued on a prorata basis determined by deposits paid to date under Plan III. (9) I understand that so long as the above covenants are fulfilled by me I may convert my Medical-Professional Liability Insurance to any other Casualty Indemnity Exchange Plan in effect at the time of intended conversion, without prejudice or penalty.

I understand that this agreement becomes a part of my application for Medical-Professional Liability Insurance with Casualty Indemnity Exchange, and will become a part of the policy if issued.

C.I.E. Plan III Arbitration Agreement, Form JPU050772.

51. See *Infra*, pp. 327ff.

52. See sections (1) and (2) of the insurance application, Note 50 supra.

53. See *Infra*, pp. 328ff.

54. Immediately following a form designed to obtain relevant patient information, there appears this contract:

TREATMENT AND ARBITRATION AGREEMENT

With regard to medical care and services provided or to be provided, IT IS AGREED that: THE ATTENDING PHYSICIAN will provide medical care and services to the patient, to the best of his skill and knowledge, which medical care in the light of circumstance is possible and practical. The PATIENT will cooperate fully with the ATTENDING PHYSICIAN by obtaining such medications as are prescribed, by following the instructions of the ATTENDING PHYSICIAN, by adhering to such treatment regimen or course of action as may be set forth, and by paying all fees and charges in full as billed or as provided by prior special arrangements. IT IS AGREED that: Because of differences in human constitution and response, it is in no way possible to warrant the outcome of such medical care and service.

In the event of any controversy between the PATIENT or a dependent (whether or not a minor) or the heirs-at-law or personal representative of a PATIENT, as the case may be, and the ATTENDING PHYSICIAN (including its agents and employees), involving a claim in tort or contractual, the same shall be submitted to arbitration. Within fifteen (15) days after the PATIENT or ATTENDING PHYSICIAN shall give notice to the other of demanding arbitration of such controversy, the parties to the controversy shall each appoint an arbitrator and give notive of such appointment to the other. Within a reasonable amount of time after such notices have been given, the two arbitrators, so selected, shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of neutral arbitrator. All notices or other papers required to be served shall be served by United States mail. Except as provided herein, the arbitration shall be conducted in accordance with and governed by the provisions of Title 9 of the California Code of Civil Procedure. The PATIENT may withdraw from this agreement within 30 days from the above date by notification of his intent to do so to the ATTENDING PHYSICIAN by registered mail.

By my signature, I consent to this agreement and acknowledge receipt of a true copy thereof.

Dated Patient

If the PATIENT is a minor or incompetent, the parent or guardian should sign here, and in addition the minor or incompetent PATIENT should sign above, if possible.

Dated Parent or Guardian

This form agreement is modified only to the extend necessary to incorporate the arbitration law of the state in which it is used. This is ordinarily accomplished by a brief reference to an arbitration statute.

55. See *Infra*, pp 326ff.

56. It seems a strained construction to read the withdrawal clause to apply only to the arbitration portion of the agreement.

57. E.g., Obering v. Swain-Roach Lumber Co., 86 Ind. App. 632, 155 N.E. 712 (1927). Cf., Paul v. Rosen, 3 Ill. App.2d 423 (1954). Some courts would find sufficient mutuality in the patient's obligation to effect termination by registered mail.

58. This prospective use of the arbitral mechanism is, to be sure, motivated in part by insurance considerations, particularly the difficulties in forecasting insurance underwriting costs of liability claims for any claims year. See Note, Arbitration of Medical Liability, 211 J.A.M.A. 175 (1970); Ludlam and Hassard, supra note 48, at 58.

59. See generally 2 S. Williston, Contracts § § 222-56 (3rd ed. 1957); Restatement (Second) of Contracts § § 13, 18, 18C (Tent. Draft No. 1, 1964) (hereinafter cited as Rest.2d). Today the trend is away from the concept of "void" contracts in instances of lack of capacity, it being thought more accurate to regard such contracts as "voidable." Cundick v. Broadbent, 383 F.2d 157 (10th Cir. 1967).

60. The common law rule fixing the age of full capacity to contract at twenty-one has been changed by statute or case law in many states; indeed, legislative modification is currently proceeding at an accelerated pace, with an apparent preference for eighteen as the age of majority for many purposes. See, e.g., Va. Code Ann. § 1-13.42 (Supp. 1972). Compare Kiefer v. Fred Howe Motors, Inc., 39 Wis.2d 20, 158 N.W.2d 288 (1968). If an infant is a contracting party, the general rules of infants' contracts extend even to arbitration agreements in the absence pf a controlling statute. Domke § 10.01. Many states have such statutes. Cf., Goldenberg v. Goldenberg, 25 A.D.2d 670, 268 N.Y.S.2d 383 (1966).

61. 62 Cal.2d 606, 401 P.2d 1 (1965).

62. Id. at 608, 401 P.2d at 3.

63. Ibid.

64. In comparison with other powers guardians and parents are given over the causes of action of infants, the court found the arbitration requirement to be a lesser restriction on infants' rights. Id. at 608, 401 P.2d at 3.

65. New York forbids arbitration "involving an infant" unless court approval is obtained on application of the infant. The statute reads: "A controversy involving an infant or person judicially declared to be incompetent shall not be submitted to arbitration except pursuant to a court order made upon application of the representative of such infant or incompetent." N.Y. Civ. Pract. Law § 1209 (McKinney 1963).

66. Coughlin v. Motor Vehicle Acc. Indem. Corp., 45 Misc.2d 672, 257 N.Y.S.2d 549 (1965); Chernick v. Hartford Acc. & Indem. Co., 8 N.Y.2d 756, 201 N.Y.S.2d 774, 168 N.E.2d 110 (1960).

67. The statutory phrase "involving an infant" has been read to require that the infant be a contractual party. Thus the statute does not apply to the separation agreement of spouses, even though a support controversy affects children of the parties. Schneider v. Schneider, 24 A.D.2d 768, 264 N.Y.S.2d 9 (1965), aff'd. 17 N.Y.2d 123, 269 N.Y.S.2d 107, 216 N.E.2d 318 (1966).

68. The banking, insurance and educational loan fields are leading examples of statutorily binding infants' contracts. See, e.g., Va. Code Ann. § 38.1-436 (Supp. 1970).

69. E.g., Keser v. Chagnon, 159 Colo. 209, 410 P.2d 637 (1966); Pankas v. Bell, 413 Pa, 494, 198 A.2d 312 (1964).

70. If a state includes medical services in the common law category of "necessaries," an infant recipient may be said to be contractually liable, even though such liabilities ar more accurately regarded as quasi-contractual. See generally 2 S. Williston, Contracts § § 240, 255, 262 (3rd ed. 1957); Restatement of Restitution § § 62, 112-17, 139 (1937). The only relevance of the point here is that non-contractual sources of infant obligation may influence the decision to impose the arbitral term of dependent insurance coverage.

71. The capacity question usually arises in a commercial transaction involving the transfer of real or personal property. E.g., Moran v. Paine, Webber, Jackson & Curtis, 422 Pa. 66, 220 A.2d 624 (1966); Yount v. Yount, 144 Ind. 133, 43 N.E. 136 (1895).

72. See In Re Estate of Lucas, 38 A.D.2d 784, 328 N.Y.S.2d 118 (1972). The extent of judicial supervision over the business dealings of a mental incompetent is illustrated by Davis v. Colorado Kenworth Corp., 156 Colo. 98, 396 P.2d 958 (1964).

73. See Rest.2d § 18C, comment a at 65-66 (Tent. Draft No. 1, 1964).

74. Aldrich v. Bailey, 132 N.Y. 85, 89, 30 N.E. 264, 265 (1931). See generally Green, Judicial Tests of Mental Incompetency, 6 Mo. L. Rev. 141 (1941).

75. Green, Proof of Mental Incompetency and the Unexpressed Major Premise, 53 Yale L. J. 271 (1944).

76. The restatement formulation appears in Section 18C:

> (1) A person incurs only voidable contractual duties by entering into a transaction if by reason of mental illness or defect
>
> (a) he is unable to understand in a reasonable manner the nature and consequences of the transaction, or
>
> (b) he is unable to act in a reasonable manner in relation to the transaction and the other party has reason to know of his condition.
>
> (2) Where the contract is made on fair terms and the other party is without knowlege of the mental illness or defect, the power of avoidance under subsection (1) terminates to the extent that the contract has been so performed in whole or in part or the circumstances have so changed that avoidance would be inequitable. In such a case a court may grant relief on such equitable terms as the situation requires.

Rest. 2d § 18C (Tent. Draft No. 1, 1964).

77. Ortelere v. Teachers' Retire. Bd. of N.Y., 25 N.Y.2d 196, 250 N.E.2d 460 (1969).

78. Compare Weseman v. Latham. 153 Cal. App.2d 841, 315 P.2d 364 (1957), with Verstandig v. Schlaffer, 296 N.Y. 62, 70 N.E.2d 15 (1946).

79. For cases and discussion, see Green, supra note 75, at 297-305.

80. Thus, the risk that assumptions upon which the system of freedom of contract is built will be undermined by an erroneous decision of the question is considerably lessened.

81. The fact the incompetency defense is raised in the narrow context of an action to compel arbitration tends to focus attention on the general suitability of the arbitral system. It should also be remembered that the burden of proof is usually placed on the party asserting incompetency. In that connection, proof of incompetency usually invokes factors such as the following: irrational or unintelligent behavior, prior adjudications of incompetency, age, bodily infirmity or disease, use of alcohol or drugs, illiteracy or absence of independent advice. Rest.2d § 18C, comment c at 67-68 (Tent. Draft No. 1, 1964).

82. Id., comment b, at 66-67.

83. See Ortelere v. Teachers' Retire. Bd. of N.Y., 25 N.Y.2d 196, 201, 250 N.E.2d 460, 466 (1969).

84. Doyle v. Giuliucci, 62 Cal.2d 606, 401 P.2d 1 (1965).

85. See. e.g., Shepard v. Dick, 203 Kan. 164, 453 P.2d 134 (1969); Jackson v. Seymour, 193 Va. 735, 71 S.E.2d 181 (1952).

86. Lentine v. Fundaro, 29 N.Y.2d 382, 278 N.E.2d 633 (1972). See generally Mentschikoff, Commercial Arbitration, 61 Colum. L. Rev. 846 (1961).

87. The question is whether failure to raise the defense at the initial enforcement proceeding prevents its use subsequently as a ground for vacating an award. The matter is treated by statute in many states. See, e.g., Ill. Stat. Ann. ch. 10 § 112 (1966); N.Y. Civ. Pract. Law § 7511 (McKinney 1963). As a practical matter, a court is not likely to look favorably on a defense going to the consent issue if a party has knowingly gone to arbitration without raising it. See Moran v. Paine, Webber, Jackson & Curtis, 422 Pa. 66, 220 A.2d 624 (1966).

88. The Uniform Arbitration Act, for example, provides in Section 2:

> (a) On application . . ., the court shall order the parties to proceed with arbitration, but if the opposing party denies the existence of the agreement to arbitrate, the court shall proceed summarily to the determination of the issue . . .
>
> (b) On application, the court may stay an arbitration proceeding . . on a showing that there is no agreement to arbitrate. That issue, when in. . . dispute, shall be forthwith and summarily tried . . .

9 Uniform Laws Ann. (1957). See also 9 U.S.C.A. §4 (1970).

89. The scope of agreement, or the issue of arbitrability, is also supposedly an issue for the court. See Harrison F. Blades, Inc. v. Jarman Mem. Hosp. Bldg. Fund, Inc., 109 Ill. App.2d 224, 248 N.E.2d 289 (1969). Many statutes, in addition to the issue of existence of contract, specify that the court may consider that of compliance with the agreement. N.Y. Civ. Pract. Law § 7503 (McKinney 1963).

90. E.g., Cal. Code Civ. Pro. § 1281.2 (West 1972): ". . . If the court determines that a written agreement to arbitrate . . . exists, an order to arbitrate . . . may not be refused on the ground that the petitioner's contentions lack substantive merit." See Bd. of Education v. Grand Island Teachers' Ass'n, 324 N.Y.S.2d 717 (Sup. Ct. 1970).

91. For a representative recent example, see Dorton v. Collins & Aikman Corp., 453 F.2d 1161 (6th Cir. 1972).

92. See generally Domke §§ 7.01-.02; Sonderby, Commercial Arbitration: Enforcement of An Agreement to Arbitrate Future Disputes, 5 J. Marsh, J. Prac. & Proc. 72, 83-86 (1971). It should be noted that the hospital admissions' form used in the California pilot plan incorporates by reference fairly detailed Hospital Arbitration Regulations. See Ludlam and Hassard, Arbitration, 44 J.A.H.A. 58, 60-62 (1970).

93. Vargas v. Esquire, 166 F.2d 651 (7th Cir. 1948). But see Cutler Corp. v. Latshaw, 374 Pa. 1, 97 A.2d 234 (1953). It has been held that failure to read the arbitration provision in the contract is no defense to enforceability. Federico v. Frick, 3 Cal App.3d 872, 84 Cal. Rptr. 74 (1970).

94. See notes 46-49 supra and accompanying text.

95. Uniform Commercial Code §§ 1-201(10), 2-316. As to whether a term in a lengthy, technical contract is "conspicuous," see Gray v. Zurich Ins. Co., 54 Cal. Rptr. 104, 419 P.2d 168 (1966).

96. See, e.g., Moran v. Paine, Webber, Jackson & Curtis, 422 Pa. 66, 220 A.2d 624 (1966). Ignorance of the nature of arbitral proceedings has been held an infeffective defense, at least when raised after award. Federico v. Frick, 3 Cal. App.3d 872, 84 Cal. Rptr. 74 (1970).

97. E.g., Gerhardt v. Continental Ins. Co., 48 N.J. 291, 225 A.2d 328 (1966). This approach to construction is of course consistent with traditional practice in contract.

98. See generally K. Llewellyn, The Common Law Tradition: Deciding Appeals 370-71 (1960). Cf., Tunkl v. Regents of Univ. of Calif., 32 Cal. Rptr. 33, 383 P.2d 441 (1963).

99. E.g., Allied Van Lines, Inc. v. Hollander Expr. & Van Co., 35 A.D.2d 91, 315 N.Y.S.2d 162 (1970).

100. Doughboy Industries, Inc. v. Pantasote Co., 17 A.D.2d 216, 220, 233 N.Y.S.2d 488, 492 (1962).

101. Harrison F. Blades, Inc. v. Jarman Mem Hosp. Bldg. Fund, Inc., 109 Ill. App. 2d 224, 248 N.E.2d 289, 290 (1969).

102. Uniform Commercial Code § 2-207; Roto-Lith, Ltd. v. Bartlett & Co., 297 F.2d 497 (1st Cir. 1962).

103. See generally Collins, Arbitration and the Uniform Commericial Code, 41 N.Y.U.L. Rev. 736 (1966).

104. E.g., Tanbro Fabrics Corp. v. Deering-Milliken, Inc., 35 A.D.2d 469, 318 N.Y.S.2d 764 (1971).

105. As to conceptual difficulties in balancing the contractual powers of court and arbitrator, see Kulukundis Shipping Co. v. Amtorg Trading Corp. 126 F.2d 978 (2d Cir. 1942).

106. Domke § 12.01. Contra, Sonderby, supra note 92, at 86.

107. E.g., Merritt-Chapman & Scott Corp. v. Pa. Turnpike Comm., 387 F.2d 768 (3rd Cir. 1967).

108. United Steelworkers of America v. American Mfg. Co., 363 U.S. 564, 567-68 (1960): "The function of the court is very limited when the parties have agreed to submit all questions of contract interpretation to the arbitrator. It is confined to ascertaining whether the party seeking arbitration is making a claim which on its face is governed by the contract."

109. United Steel Workers of America v. Warrior & Gulf Navigation Co., 363 U.S. 574, 582-83 (1960): "An order to arbitrate the particular grievance should not be denied unless it may be said with positive assurance that the arbitration clause is not susceptible of an interpretation that covers the asserted dispute. Doubts should be resolved in favor of coverage."

110. 363 U.S. at 578.

111. E.g., compare Ludwig Honold Mfg. Co. v. Fletcher, 405 F.2d 1123 (3rd Cir. 1969), with Harrison F. Blades, Inc. v. Jarman Mem. Hosp. Bldg. Fund, Inc., 109 Ill. App.2d 224, 248 N.E.2d 289 (1969).

112. Prima Paint Corp. v. Flood & Conklin Mfg. Co., 388 U.S. 395, 404 (1967).

113. See, e.g., Halcon Int'l., Inc. v. Monsanto Australia Ltd., 446 F.2d 156, 158 (1971); Galt v. Libby-Owens-Ford Glass Co., 376 F.2d 711, 714 (7th Cir. 1967).

114. Hamilton Life Ins. Co. v. Republic Nat'l Life Ins. Co., 408 F.2d 613, 616 (2d Cir. 1969).

115. The course of the California decisions is indicated in Morris v. Zuckerman, 257 Cal. App.2d 91, 64 Cal. Rptr. 714 (1967).

116. Matter of Exercycle (Maratta), 9 N.Y.2d 329, 173 N.E.2d 463 (1961).

117. Blum Folding Paper Box Co. v. Friedlander, 27 N.Y.2d 35, 36, 261 N.E.2d 382, 383 (1970).

118. Layne-Minnesota Co. v. Regents of Univ. of Minn., 266 Minn. 284, 123 N.W.2d 371 (1963). If intention regarding the scope of the arbitration clause is clearly expressed or ascertainable,

the Layne-Minnesota court would apparently retain and decide the arbitrability question. See generally Pirsig, Arbitrability and the Uniform Act, 19 Arb. J. 154 (1964). Cf., Mahaffy v. Gray, 242 Or. 522, 410 P.2d 822 (1966); Rosa v. Transport Ops. Co., 45 N.J. Super. 483, 133 A.2d 24 (1957).

119. Harrison F. Blades, Inc. v. Jarman Mem. Hosp. Bldg. Fund, Inc., 109 Ill. App.2d 224, 226, 248 N.E.2d 289, 291 (1969).

120. This is what the court did without expressly saying so in Flood v. Country Mut. Ins. Co., 41 Ill.2d 91, 242 N.E.2d 149 1968). But see School Dist. No. 46 v. Del Bianco, 68 Ill, App.2d 145, 215 N.E.2d 25 (1966).

121. For the clauses in full, see Notes 46-49 supra and accompanying text.

122. Doyle v. Giuliucci, 62 Cal.2d 606, 401 P.2d 1 (1965).

123. As to the obligation to arbitrate tort issues arising from a contractual performance, see Domke § 13.08.

124. An earlier Ross-Loos arbitration clause in a group medical contract with a relief association was held not to include personal damage claims by individuals. Spanach v. Sup. Ct. of Los Angeles County, 4 Cal.2d 447, 43 P.2d 339 (1935).

125. Counsel instrumental in the drafting of the clause have stated: "Consideration was given to limiting the arbitration option to malpractice claims, but this idea was rejected on the grounds that it would make the agreement unilateral." Ludlam & Hassard, Arbitration, 44 J.A.H.A. 58, 60 (1970).

126. E.g., Application of Dana Realty Corp., 21 A.D.2d 769, 250 N.Y.S.2d 784 (1964).

127. For example, Section 1 of the Uniform Act reads in part:

> "A written agreement to submit . . . to arbitration . . . any controversy thereafter arising . . . is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any such agreement."

9 Uniform Laws Ann. 78 (1957).

128. See generally Rest.2d § § 13, 14, 19 (Tent. Draft No. 1, 1964).

129. In New York, for example, the only practical grounds for vacation of an award are a showing that the arbitrator exercised powers expressly forbidden by the contract, or a finding that his application of the contract is "completely irrational." Lentine v. Fundaro. 29 N.Y.2d 382, 278 N.E.2d 633 (1972). For a useful recent discussion of the standard for judicial review of labor and commercial awards, see Ludwig Honold Mfg. Co. v. Fletcher, 405 F.2d 1123 (3rd Cir. 1969).

130. See generally Nussbaum, The Separability Doctrine in American and Foreign Arbitration, 17 N.Y.U.L.Q. Rev. 609 (1940).

131. 271 F.2d 402 (2d Cir. 1959), cert. dismissed 364 U.S. 801 (1960). It is to be recalled that this case pinned down the point that the United States Arbitration Act creates national substantive law to be administered by the Federal courts on all questions of interpretation and validity of arbitration agreements. 271 F.2d at 409. Contra, Lummus Co. v. Commonwealth Oil Ref. Co., 280 F.2d 915 (1st Cir. 1960), cert. denied 364 U.S. 911 (1960).

132. E.g., J.P. Greathouse Steel Erectors, Inc. v. Blount Bros. Constr. Co., 374 F.2d 324 (D.C. Cir. 1967); In re Kinoshita & Co., 287 F.2d 951 (2nd Cir. 1961). Cf. El Hoss Eng'r. & Transport Co. v. American Ind. Oil Co., 289 F.2d 346 (2d Cir. 1961).

133. Hellenic Lines, Ltd. v. Louis Dreyfus Corp., 372 F.2d 753, 758 (2d Cir. 1967); Robert Lawrence Co., Inc. v. Devonshire Fabrics, Inc., 271 F.2d 402, 411 (2nd Cir. 1959), cert. dismissed 364 U.S. 801 (1960); Amicizia Societa Navigazione v. Chilean Nitrate & Iodine Sales Corp., 274 F.2d 805 (2d Cir. 1959), cert. denied 363 U.S.843 (1960).

134. See Domke § 8.02. But see Moseley v. Electronic Facilities, 374 U.S. 167 (1963).

135. 388 U.S. 395 (1967).

136. Section 4 reads in part:

> "The court shall hear the parties, and upon being satisfied that the making of the agreement for arbitration or the failure to comply therewith is not in issue, the court shall make an order directing the parties to proceed to arbitration in accordance with the terms of the agreement . . . If the making of the arbitration agreement or the failure, neglect, or refusal to perform the same be in issue, the court shall proceed summarily to the trial thereof."

9 U.S.C.A. § (1970).

137. The court's construction regards the arbitration clause, not the general contract, to be the reference point of the prescribed "making." 388 U.S. at 403-04.

138. The *Prima Paint* opinion extends its analysis to Section 3 proceedings as well, where a stay of litigation is sought pending arbitration, despite differences in language between Sections 3 and 4. 388 U.S. at 403-04.

139. Operating Engineers, Local 150 v. Flair Builders, Inc., 80 L.R.R.M. 2441 (U.S. Sup. Ct. 1972), holding that an employer's claim that certain union grievances are barred by laches is an arbitrable question for the arbitrator to decide under a broad clause.

140. Halcon Int'l., Inc. v. Monsanto Australia Ltd., 446 F.2d 156 (7th Cir. 1971); Trafalgar Shipping Co. v. Int'l. Milling Co., 401 F.2d 568 (2d Cir. 1968).

141. World Brilliance Corp. v. Bethlehem Steel Co., 342 F.2d 362 (2d Cir. (1965).

142. County of Middlesex v. Gevyn Constr. Co., 450 F.2d 53 (1st Cir. 1971).

143. Various issues arising in commercial arbitration, such as patent, anti-trust and securities questions of legality, have been held non-arbitrable because it is deemed against public policy to permit an arbitrator to delve into areas regulated by comprehensive statutes. See, e.g., American Safety Equipment Co. v. J. P. Maguire Co., 391 F.2d 821 (2d Cir. 1968); Aimcee Wholesale Corp. v. Tomar Products, Inc., 21 N.Y.2d 621, 237 N.E.2d 223 (1968); Wilko v. Swan, 346 U.S. 427 (1953). On the question of scope of review of arbitration awards allegedly offensive to public policy, see Dunau, Three Problems in Labor Arbitration, 55 Va. L. Rev. 427, 441-47 (1969).

144. Prima Paint Corp. v. Flood & Conklin Mfg. Co., 388 U.S. 395, 402 n.9 (1967).

145. One court distinguishes the conditions precedent cases from the fraudulent inducement cases in part on the ground the latter frustrate arbitration because a preliminary court adjudication would be required each time the claim is raised, whereas "there is no likelihood of sham litigation to avoid submitting" issues of condition to arbitration. El Hoss Eng'r. & Transport Co. v. American Indep. Oil Co., 289 F.2d 346, 349 (2d Cir. 1961). Cf., Methodist Church v. Glen-Rich Constr. Co., 27 N.Y.2d 357, 267 N.E.2d 88 (1971); Bangor Punta Operations, Inc. v. Carnaby Knitting Corp., 37 A.D.2d 513, 321 N.Y.S.2d 806 (1971).

146. County of Middlesex v. Gevyn Constr. Co., 450 F.2d 53, 55-56 (1st Cir. 1971).

147. World Brilliance Corp. v. Bethlehem Steel Co., 342 F.2d 362, 364 (2d Cir. 1965). Moreover, the phrase "failure, neglect or refusal" to arbitrate, which appears twice in Section 4, 9U.S.C.A. § 4 (1970), does not appear to supply a basis for enlarging court disposition of commercial arbitration issues. In addition to having received a narrow construction, this portion of the statute presumably raises an issue only when the party resisting arbitration in court takes the position he has not failed, neglected or refused to arbitrate. 342 F.2d at 365; Trafalgar Shipping Co. v. Int'l. Milling Co., 401 F.2d 568, 571-72 (2d Cir. 1968). Since the parties would not be in court were it not for the fact that one of them failed, neglected or refused to arbitrate, the occasions for raising the issue will not by many. Hence this Section 4 language offers little support for increased court authority under the "making" test.

148. Section 2 reads in part:

> A written provision in . . . a contract . . . to settle by arbitration a controversy thereafter arising . . . shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

9 U.S.C.A. § 2 (1970).

149. See generally Halcon lnt'l., Inc. v. Monsanto Australia Ltd., 446 F.2d 156, 158-60 (7th Cir. 1971). Even without the supporting statutory analysis, the separability theory produces an identical result. Amicizia Societa Navigazione v. Chilean & lodine Sales Corp. 274 F.2d 805 (2d Cir. 1959), cert. denied 363 U.S. 843 (1960) (claim of mutual mistake is within province of arbitration since broad clause separable).

150. Prima Paint Corp. v. Flood & Conkline Mfg. Co., 388 U.S. 395, 404 n.12 (1967).

151. Id. at 404-05.

152. lt is to be remembered that *Prima Paint* speaks only to limitations upon the power of Federal courts to litigate contract defenses when the parties have bargained broadly for arbitration.

153. E.g., Wrap-Vertiser Corp. v. Plotnick, 3 N.Y.2d 17, 163 N.Y.S.2d 639, 143 N.E.2d 17 (1957).

154. Aksen, Prima Paint v. Flood & Conkline—What Does lt Mean?, 43 St. John's L. Rev. 1, 9 (1968).

155. E.g., City of Madison v. Frank Lloyd Wright Foundation, 20 Wis.2d 361, 122 N.W.2d 409 (1963).

156. 9 N.Y.2d 329, 214 N.Y.S.2d 353, 174 N.E.2d 463 (1961).

157. 9 N.Y.2d at 334, 214 N.Y.S.2d at 355, 174 N.E.2d at 214.

158. lbid.

159. Judicial control over the second type of issue is administratively justified. See. e.g., American Silk Mills Corp. v. Meinhard-Comm. Corp., 38 A.D.2d 695, 328 N.Y.S.2d 103 (1972). The third type of issue, public policy disputes arising out of contracts containing arbitration clauses, does not appear to have been extended by the New York courts to many non-statutory areas. See Bd. of Education v. West lslip Teachers Ass'n., 68 Misc.2d 830, 328 N.Y.S.2d 266 (1972).

160. Some uncertainty about the vitality of *Exercycle* has arisen because of a 1962 amendment adding the word "valid" to § 7503(a) of the New York act. As amended, that section states in relevant part:

> "A party aggrieved by the failure of another to arbitrate may apply for an order compelling arbitration. Where there is no substantial question whether a *valid agreement was made* or complied with . . . the court shall direct the parties to arbitrate. Where any such question is raised, it shall be tried forthwith in said court. (Emphasis added.)

N.Y.Civ. Pract. Law § 7503 (a) (Mckinney 1963). Presumably this amendment was not designed to recapture for the courts issues ceded to arbitration by *Exercycle.* ld., 1965 Supp. Pract. Commentary § 7503, at 156-57 (McKinney Supp. 1972).

161. Methodist Church v. Glen-Rich Constr. Co., 27 N.Y.2d 357, 267 N.E.2d 88 (1971).

162. See, e.g., Hamilton Life Ins. Co. v. Republic Nat'l. Life Ins. Co., 408 F.2d 613, 619 (2d Cir. 1969); Matter of Amphenol Corp., 49 Misc.2d 46, 266 N.Y.S.2d 768 (1965), aff'd. 25 A.D.2d 497, 267 N.Y.S.2d 477 (1966). Cf. Durst v. Abrash, 22 A.D.2d 39, 253 N.Y.S.2d 351 (1964).

163. The following cases are offered as a sample of recent referrals to arbitration: Popular Publications, Inc. v. McCall Corp., 36 A.D. 927, 321 N.Y.S.2d 308 (1971) (events resulting in termination of main contract); Blum Folding paper Box Co. v. Friedlander, 27 N.Y.2d 35, 261 N.E.2d 382 (1970) (interpretation repecting scope of arbitration agreement); Methodist Church v. Glen-Rich Constr. Co., 27 N.Y.S.2d 357, 267 N.E.2d 88 (1971) (performance of conditions of duty); Weiss v. Manassee, 36 A.D.2d 555, 317 N.Y.S.2d 579 (1971) (defense of abandonment of contract).

164. Aksen, Prima Paint v. Flood & Conkline—What Does it Mean?, 43 St. John's L. Rev. 1, 10 (1968).

165. Merritt-Chapman & Scott Corp. v. Penn. Turnpike Comm., 387 F.2d 768, 771 (3rd Cir. 1967).

166. For purposes of arbitral comparison, see Note, Predictability of the Result of Commercial Arbitration, 61 Harv. L. Rev. 1022 (1948).

167. See, e.g., Ludwig Honold Mfg. Co. v. Fletcher, 405 F.2d 1123, 1131-32 (3rd Cir. 1969).

168. Domke at 30.

169. See Aksen, note 164 supra at 10-11; Domke § 8.05.

170. It was the intention of the drafters of the Uniform Arbitration Act to cover only "voluntary" agreements. 9 Uniform Laws Ann., Commr's. Prefatory Note at 76 (1957).

171. See notes 93-104 supra and accompanying text. There is case authority holding that failure to read an arbitration provision is not itself reason to deny an order of arbitration. Frame v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 20 Cal. App. 3d 668, 97 Cal. Rptr. 811 (1971).

172. R. I. Gen. Laws Ann. § 10-3-2 (1956).

173. Tex. Rev. Civ. Stat. Ann. art. 224 (Vernon Supp. 1970). In addition, a variety of requirements designed to insure awareness of the arbitration agreement have been adopted in other states—e.g., execution, signature, acknowledgment or filing requirements. See, e.g., Ala. Code tit. 7, § 831 (Supp. 1960); Idaho Code Ann. § 7-903 (1947); Iowa Code Ann. § 679.2 (1966); Mont. Rev. Code Ann. § 93-201-3 (1964).

174. Whatever the explanation, it is interesting to note that of the thousands of hospital admissions pursuant to the form used in the California pilot project, "practically all" have agreed to the arbitration term. Arbitration News, No. 5, June 1972, at 4. As of this writing, "relatively few arbitration cases have resulted." Id., No. 3, Mar.-April 1972, at 4.

175. Many courts are still sensitive to the prospective operation of an arbitration clause. E.g., Donahue v. Associated Indem. Corp. 227 A. 2d 187 (R.l. 1967).

176. 372 F. 2d 753 (2d Cir. 1967).

177. 372 F. 2d at 758: "A finding of duress at least must reflect a conviction that one party to a transaction has been so improperly imposed upon by the other that a court should intervene."

178. Ibid. See generally Dawson, Economic Duress—An Essay in Perspective, 45 Mich. L. Rev. 253 (1947).

179. The classic in the literature is still Kessler, Contracts of Adhesion—Some Thoughts about Freedom of Contract, 43 Colum. L. Rev. 629 (1943).

180. Id., at 631.

181. 388 U.S. 395 (1967).

182. 388 U.S. at 403 n. 9.

183. Section 1 reads in full:

> 'Maritime transactions,' as herein defined means charter parties, bills of lading of water carriers, agreements relating to wharfage, supplies furnished vessels or repairs to vessels, collisions, or other matters in foreign commerce which, if the subject of controversy, would be embraced within admiralty jurisdiction; 'commerce,' as herein defined, means commerce among the several states or with foreign nations, or in any Territory of the United States or in the District of Columbia, or between any such Territory and another, or between any such Territory and any state or foreign nation, or between the District of Columbia and any State or Territory or foreign nation, but nothing herein contained shall apply to contracts of employment of seamen, railroad employees, or any other class of workers engaged in foreign or interstate commerce.

9 U.S.C.A. § 1 (1970).

184. 388 U.S. at 400 n. 4.

185. See Aksen, Prima Paint v. Flood & Conklin - What Does It Mean? 43 St. John's L. Rev. 1, 12-13 (1968).

186. See, e.g., lsaacs, The Standardizing of Contracts, 27 Yale L.J. 34 (1917). Cf., Childres and Spitz, Status ln The Law of Contract, 47 N. Y. U. L. Rev. 1 (1972).

187. The traditional common law approach is illustrated in Gray v. Zurich, 54 Cal. Rptr. 104, 419 P.2d 168 (1966).

188. Neal v. State Farm Ins. Cos., 188 Cal. App. 2d 690, 695, 10 Cal. Rptr. 781, 784 (1961): 'rtthe rule that any ambiguities caused by the draftsman of the contract must be resolved against that party. . . applies with peculiar force in the case of one contract of adhesion.

189. Uniform Commercial Code § § 1-203, 2-209; Rest. 2d 231

(Tent. Draft No. 5, 1970). See generally Summers, "Good Faith" in General Contract Law and the Sales Provisions of the Uniform Commercial Code, 54 Va. L. Rev. 195 (1968).

190. Uniform Commercial Code § 2-302; Rest. 2d § 234 (Tent. Draft No. 5, 1970). Though the term is undefined, the determination that a contract is unconscionable is usually made in the light of its "setting, purpose and effect," taking into account such factors as "weaknesses in the contracting process like those involved in more specific rules as do contractual capacity, fraud and other invalidating causes." Id., comment a at 107.

191. Kessler, supra note 179, at 637.

192. Federico v. Frick, 3 Cal. App. 3d 872, 84 Cal. Rptr. 74 (1970).

193. Frame v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 20 Cal. App. 3d 668, 670, 97 Cal. Rptr. 811, 813 (1971).

194. Play v. Geo. M. Brewster & Son, Inc., 18 Cal. App. 3d 526, 96 Cal. Rptr. 149 (1971). The decision contained an alternative ground of arbitrability.

195. The court detected in other California decisions an "inclination to limit the use of arbitration where the arbitration 'agreement' may give advantage to one party thereto." Id. at 532, 96 Cal. Rptr. at 152.

196. Id. at 537, 96 Cal. Rptr. at 155-56.

197. It would appear that the election feature of the hospital admissions' form in the California project, operative at either the time of contract or within thirty days of discharge, does far to minimize the claim of forced adherence. See Ludlam and Hassard, Arbitration, 44 J.A.H.A. 588, 59 (1970).

198. "Our trial courts are clogged with cases,. . . .involving disputes between contracting parties. One of the principal purposes which arbitration proceedings accomplish is to relieve that congestion and to obviate the delays of litigation." Player v. Geo. M. Brewster & Son, Inc., 18 Cal. App. 3d 526, 534, 96 Cal. Rptr. 149, 154 (1971). Moreover, there is developing pressure to adopt and expand even non-consensual systems of arbitration. See, e.g., Rosenberg and Shubin, Trial by Lawyer: Compulsory Arbitration of Small Claims in Pennsylvania, 74 Harv. L. Rev. 448 (1961).

199. Doyle v. Giuliucci, 62 Cal. 2d 606, 401 P.2d 1 (1965).

200. See Frame v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 20 Cal. App. 3d 668, 672, 97 Cal. Rptr. 811, 813 (1971).

201. See notes 78-84 supra and accompanying text.

202. Aksen, supra note 185, at 13.

203. Note, Medical Arbitration Experiments, 211 J.A.M.A. 351, 352 (1970). One medical authority expresses the view: "The indication appears to be that, on an average, the frequency and amount of arbitration awards are not apt to differ substantially from court judgments, but may tend to avoid extremes." Note, Arbitration of Medical Liability, 211 J.A.M.A. 175 176 (1970). One of the stated reasons for undertaking the California hospital project was to "reduce the amount of those judgments that may have been established by emotion or theatrical appeals to a jury." Coulson, Should Medical Malpractice Claims Be Arbitrated? Unpub. Memo., Am. Arbitration Ass'n., 13 (Oct. 1970).

204. See, e.g., Frostifresh Corp. v. Reynoso, 52 Misc. 2d 26, 274 N.Y.S. 2d 757 (1966), rev'd on damages issue 54 Misc. 2d 119, 281 N.Y.S. 2d 964 (1967).

205. See Rest. 2d § 237 (Tent. Draft No. 5, 1970).

206. See Coulson, supra note 203, at 15. There is evidence that arbitration is not being pressed in situations where genuine patient consent is doubtful. See, e.g., Arbitration News, No. 9, Nov. 1971, at 2.

207. 60 Cal. 2d 92, 383 P.2d 441 (1963).

208. The cases are collected in Annot., 175 A. L. R. 8 (1948).

209. In the opinion of the Tunkl court, a contract affected with a public interest involves a transaction exhibiting some or all of the following characteristics:

> "It concerns a business of a type generally thought suitable for public regulation. The party seeking exculpation is engaged in performing a service of great importance to the public, which is often a matter of practical necessity for some members of the public. The party holds himself out as willing to perform this service for any member of the public who seeks it, or at least for any member coming within certain established standards. As a result of the essential nature of the service, in the economic setting of the transaction, the party invoking exculpation possesses a decisive advantage of bargaining strength against any member of the public who seeks his services. In exercising a superior bargaining power the party confronts the public with a standardized adhesion contract of exculpation, and makes no provision whereby a purchaser may pay additional reasonable fees and obtain protection against negligence. Finally, as a result of the transaction, the persons or property of the purchaser is placed under the control of the seller, subject to the risk of carelessness by the seller or his agents." (Footnotes omitted).

60 Cal. 2d at 98-101, 383 P. 2d at 445-46

210. Id., at 103, 383 P. 2d at 447.

211. Ibid.

212. See, e.g., O'Callaghan v. Waller & Beckwith Realty Co., 15 Ill. 2d 436, 155 N. E. 2d 545 (1959).

213. See Akin v. Bus. Title Corp., 70 Cal. Rptr. 287 (Ct. App. 1968).

ALTERNATIVES TO LITIGATION, IV: THE LAW OF ARBITRATION IN THE U. S.

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Summary

Viewed in the practical context, for arbitration to be a viable alternative to litigation, two elements within the scope of arbitral agreement must have a statutory foundation not given by the common law—that is, provision that future as well as existing disputes may validly be the subject of an arbitral agreement, and that the arbitration contract itself will be binding and enforceable.

This study deals with the framework for arbitration as it exists in the United States. The law of the 51 jurisdictions is examined in relation to its applicability in resolving medical malpractice claims. Thirteen jurisdictions do not recognize the validity of submitting future as well as existing disputes to arbitration. While only nine were found to have reported appellate decisions indicating that arbitration has been employed to resolve personal injury claims, only four jurisdictions statutorily preclude or limit the resolution of personal injury claims by arbitration.

Allowing for the overlapping of these attributes which restrict or prohibit the use of arbitration it is concluded that a fully viable alternative to litigation by arbitration is worthy of future research and could probably be achieved in at least 31 jurisdictions.

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I. Introduction

This survey of state law was aimed chiefly at:

- determining what major obstacles now exist to the use of arbitration for the settlement of medical malpractice disputes;
- reviewing the extent to which there has been any specific legislative or appellate judicial reinforcement of the availability and effectiveness of arbitration in such circumstances; and
- providing a comparative summary of state provisions on arbitration procedure which might be considered by those desiring to institute new programs for arbitration of disputes over professional liability for medical or hospital care.

The format of the study was to find the answers to a set of specific questions, which are set forth at the beginning of the accompanying compendium of "Jurisdictional Briefs", in which a review of each state's statutes, reported appellate decisions, and opinions of attorneys general are dealt with in a uniform format for each jurisdiction.

II. Major Findings

A. THE GROWTH OF LEGISLATIVE ENACTMENT

Although a few states had arbitration statutes prior to the Civil War and a number prior to the First World War, the explosive growth of legislative enactments occurred after that period upon the promulgation of the first Uniform Arbitration Act in the early 1920s. Support was given to this growing momentum upon the founding of the American Arbitration Association in 1926. These events are displayed in Figure 1. It is interesting to note that the rate of statutory enactment over the past two decades was twice that for the preceding 20 years.

B. SUMMARY OF STATUTORY FOUNDATION

Of the 51 jurisdictions analyzed, 48 were found to have arbitration statutes. Some are quite old and limited in scope, the earliest apparently having been enacted in 1849. An increasing number of states in recent years have either adopted the Uniform Arbitration Act or enacted laws substantially influenced by it.

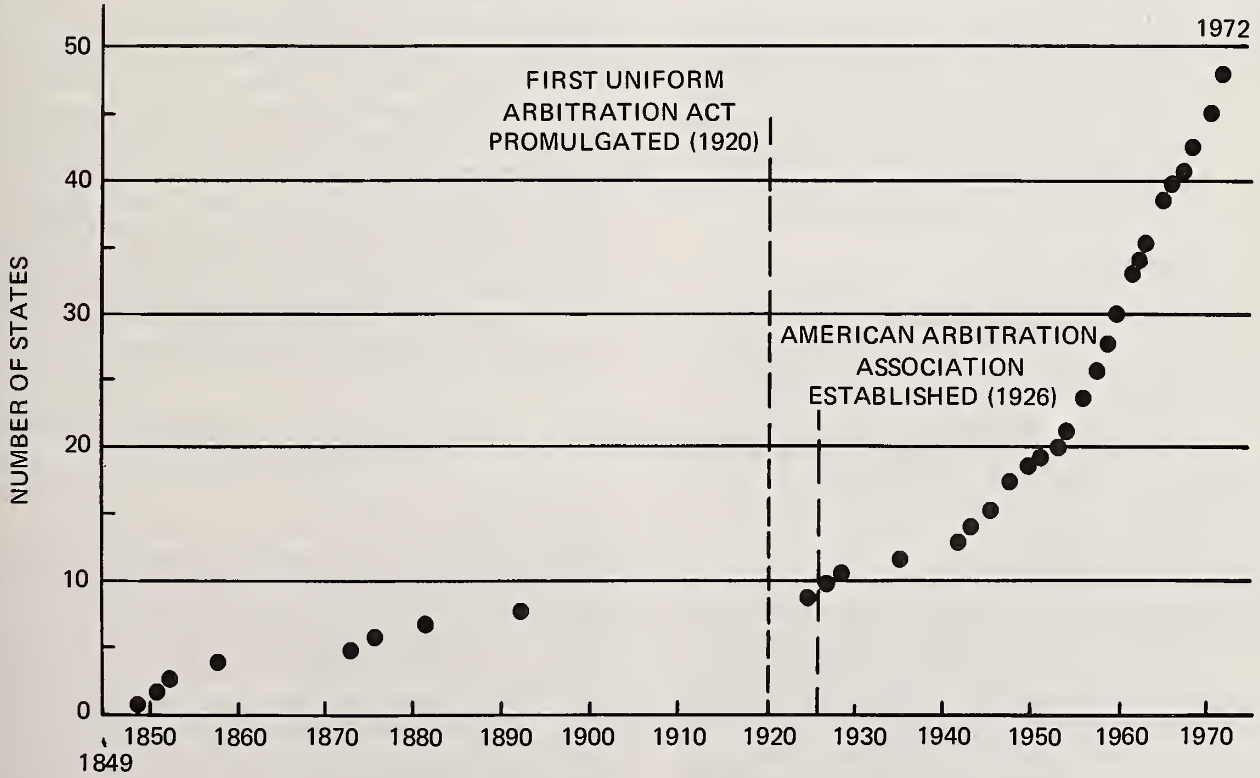

FIGURE 1

CUMULATIVE NUMBER OF STATES WITH ARBITRATION STATUTES ENACTED 1849 TO 1872

The three jurisdictions which have not enacted general arbitration statutes include Oklahoma and Vermont, which have specialized arbitration statutes for the arbitration of labor disputes; and the District of Columbia, where Congress has ratified a single provision permitting arbitration of small claims. In addition to the statutory provisions, common law arbitration is widely considered to survive. Forty-three jurisdictions have held that statutory arbitration is not in derogation of the common law and have thus recognized this continuing validity of common law arbitration. Only Washington has held that the rights of the parties are controlled wholly by statutory provisions.

C. PROCEDURAL ATTRIBUTES OF THE STATUTES

Power To Subpoena

Of the 48 jurisdictions where a general arbitration statute has been enacted, subpoena power is given directly to the arbitrators in some, while in others the power of subpoena is administered under the jurisdiction of the courts. Regardless of this, the subpoena power and the means of enforcement appear to be substantially identical.

Five jurisdictions—Delaware, Idaho, Montana, Virginia, and West Virginia—do not specifically preclude the power of subpoena in their arbitration statutes, but rather fail to mention it specifically.

Testimony Under Oath

Only Georgia, Kansas, Mississippi, Nebraska, and Pennsylvania specifically require, in their general arbitration statute, that testimony given at arbitration hearings be made under oath. Of the remaining 43 jurisdictions with arbitration statutes, only Missouri (in a decision of its Supreme Court) has held that it is the duty of the arbitrators to require witnesses to testify under oath.

Rules of Evidence

Only Georgia specifically requires that strict rules of evidence be observed. However, in Nebraska, failure to conduct hearings pursuant to rules of evidence might be a sufficient reason for vacating an award; and in Virginia, the courts have consistently invalidated awards where failure to conduct the proceedings in accordance with evidentiary rules undermined, or may have undermined, the fairness of the proceedings.

Requirement for Transcripts

No jurisdiction requires specifically that a transcript of the arbitration hearings be made. As a general rule, however, where a statute has been enacted, either party may bring a reporter to the hearing. Although the law on this point was unclear in New Jersey, New Mexico, and North Dakota, Illinois has a specific provision in its statute that the presence of a reporter could be made a valid condition precedent to performance under the arbitration agreement. Pennsylvania, upon the request from either party or the arbitrator, requires that testimony be taken stenographically and made a part of the record. In Maryland, the arbitrators are required to keep a record of the proceedings upon the written request of either party.

In the remaining 42 jurisdictions, it appears that the presence of a reporter can be made a condition precedent to carrying forth the arbitration agreement, although it is not specifically excluded from or included in the statute.

Finality

Of the 48 jurisdictions where a general arbitration statute has been enacted, arbitrators' awards are final and binding in 47. Only in Hawaii does this vital question appear unclear. In some jurisdictions, an arbitrator's award is not final and binding until it has been entered or docketed in a court of record. Filing deadlines range from five days to one year from the date of award for entry or docketing.

Grounds for Judicial Review

In the vast majority of jurisdictions where general arbitration statutes have been enacted, grounds for judicial review are specified in the statutes. In all but three—Alabama, Delaware, and South Carolina—grounds for judicial review are not specified in the statutes, but the case law has established standards.

De Novo Hearing

The statutes of 45 jurisdictions do not authorize the courts to hear *de novo* the subject matter of a controversy submitted to arbitration on which an award has been made. In New Jersey, the statute provides that if the arbitration award is set aside, the court, in its discretion, may direct a rehearing by the arbitrators, or the parties may be relegated to their original remedies and an action will lie on the underlying demand. In Oregon, where arbitrators refuse to rehear a controversy, it would appear that the court would hear *de novo* the subject matter of arbitration, while in effect the courts prohibit and refuse to hear *de novo* the merits of a conclusive decision when reached in the exercise of the arbitrator's honest judgment.

III. Conclusion

Viewed in the practical context, for arbitration to be a viable alternative to litigation, two elements within the scope of the arbitral agreement must have a statutory foundation not given by the common law—future as well as existing disputes may validly be the subject of an arbitral agreement, and the arbitration contract itself must be enforceable. Thirteen jurisdictions do not recognize the validity of submitting future as well as existing disputes to arbitration. While only nine states were found to have reported appellate decisions indicating that arbitration has been employed to resolve personal injury claims, only four jurisdictions statutorily preclude or limit the resolution of personal injury claims by arbitration.

Allowing for the overlapping of these attributes which restrict or prohibit the use of arbitration, it is concluded that the alternative to litigation of medical malpractice claims through arbitration might be achieved and is worthy of further research in at least 31 jurisdictions, with clear prohibitions or severe limitations in Alabama, Arkansas, Illinois, Iowa, Kansas, Kentucky, Mississippi, Missouri, Montana, Nebraska, North Carolina, South Carolina, Utah, and Virginia.

GENERAL ARBITRATION STATUTES OF THE UNITED STATES UNIFORM ARBITRATION ACT, 7 U.L.A. Sections 1-25 (1955)

United States	9 U.S.C. Sections 1-14 (1964).
Alabama	Ala. Code tit. 7, Sections 829-44 (1960).
Alaska	Alaska Stat. Ann. Sections 09.43. 010-180 (Cum. Supp. 1971).
Arizona	Ariz. Rev. Stat. Ann. Sections 12-1501-11 (Supp. 1971).
Arkansas	Ark. Stat. Sections 34-511-32 (Cum. Supp. 1972).
California	Calif. Civ. Proc. Code tit. 9, Sections 1280-94 (Supp. 1961).
Colorado	Colo. Rev. Stat. Ann. Ch. 18, Rule 109 (1963).
Connecticut	Conn. Gen. Stat. Rev. Sections 52-408-24 (1958).
Delaware	Del. Code Ann. tit. 10, Sections 5701-06 (1953).
District of Columbia	D.C.C.E. Section 11-1322 (Supp. 1972).
Florida	Fla. Stat. Ann. Sections 682.01-22 (Supp. 1972).
Georgia	Ga. Code Ann. Sections 7-101-11, 7-201-24 (1935).
Hawaii	Hawaii Rev. Stat. Sections 658-1-15 (1968).
Idaho	Idaho Code Ann. Sections 7-901-10 (1948).
Illinois	Ill. Rev. Stat. ch. 10, Sections 101-23 (Smith-Hurd 1966).
Indiana	Ind. Code Ann. Sections 3-277-248 (Burns Cum. Supp. 1971).
Iowa	Iowa Stat. Ann. Sections 679.1-19 (1966).
Kansas	Kan. Stat. Ann. Sections 5-201-13 (1963).
Kentucky	Ky. Rev. Stat. Sections 417.010-40 (1960).
Louisiana	La. Stat. Ann. Sections 9:4201-17 (1950).
Maine	Me. Rev. Stat. Ann., tit. 14, Sections 5927-49 (Cum. Supp. 1971).
Maryland	Md. Code Ann. Art. 7, Sections 1-23 (Repl. Vol. 1968 & Cum. Supp. 1971).
Massachusetts	Mass. Gen. Laws Ann. ch. 251, Sections 1-19 (Supp. 1972).
Michigan	Mich. Comp. Laws Ann. Sections 600.50001-5035 (1964) (Mich. Stat. Ann. Sections 27A.5001-35 (1962)); Mich. Ct. Rules Ann. Rule 769 (1964).
Minnesota	Minn. Stat. Ann. Sections 572.08-30 (cum. Supp. 1972).
Mississippi	Miss. Code Ann. tit. 3, Sections 279-97 (1942).
Missouri	Mo. Rev. Stat. Ann. Sections 435. 010-280 (Vernon 1959).
Montana	Mont. Rev. Stat. Ann. Sections 93.201-1-10 (1947).
Nebraska	Neb. Rev. Stat. Sections 25-2103-20 (1943).
Nevada	Nev. Rev. Stat. Sections 38.015-205 (1969).
New Hampshire	N.H. Rev. Stat. Ann. Sections 542:1-10 (1955).
New Jersey	N.J. Rev. Stat. Sections 2A:24-1-11 (1960).
New Mexico	N.M. Stat. Ann. 22-3-9-31 (Supp. 1971).
New York	N.Y. CPLR Sections 7501-7514 (McKinney 1963).
North Carolina	N.C. Gen. Stat. Ann. Sections 1-544-67 (Repl. Vol. 1969).
North Dakota	N.D. Code Ann. Sections 32-29-01-21 (1960).
Ohio	Ohio Rev. Code Ann. Sections 2711.01-15 (1953).
Oklahoma	No Statute.
Oregon	Ore. Rev. Stat. Sections 33.210-340 (1953).
Pennsylvania	Pa. Stat. Ann. tit. 5, Sections

	1-181 (1962 & Cum. Supp. 1972).
Puerto Rico	P.R. Laws Ann. ch. 3, Sections 3201-3229 (1963) (not analyzed).
Rhode Island	R.I. Gen. Laws Sections 10-3-1-20 (Reenactment 1969).
South Carolina	S.C. Code Ann. Sections 10-1901-05 (1962).
South Dakota	S.D. Stat. Ann. Sections 21-25A-1-38 (Supp. 1972).
Tennessee	Tenn. Code Ann. Sections 23-501-19 (1955).
Texas	Tex. Civ. Stat. arts. 224-38 (Vernon Cum. Supp. 1972).
Utah	Utah Code Ann. Sections 78-31-1-22 (1953).
Vermont	No Statute.
Virginia	Va. Code Ann. Sections 8-503-07 (Repl. Vol. 1957 & Supp. 1972).
Washington	Wash. Rev. Code Sections 7.04-010-220 (1963).
West Virginia	W.Va. Code, Sections 55-10-1-8 (1966).
Wisconsin	Wis. Stat. Ann. Sections 298.01-18 (1957).
Wyoming	Wyo. Stat. Ann. Sections 1-1048.1-21 (Cum. Supp. 1971).

Excluded from individual analysis are the UAA and the general arbitration statutes of the United States and Puerto Rico.

STATE-BY-STATE ANALYSIS OF GENERAL ARBITRATION STATUTES IN THE UNITED STATES

QUESTIONS PRESENTED

I. STATUTORY FOUNDATION

Has the state enacted an arbitration statute?

II. RELATIONSHIP OF STATUTE TO UAA

Is the statute enacted

a) Substantially identical to the UAA?
b) Similar to the UAA?

III. COMMON LAW ARBITRATION

In the absence of an enactment of an arbitration statute, does the state recognize the validity of common law arbitration?

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Do the arbitrators have power to subpoena witnesses to attend arbitration hearings?
b) Does the statute require that testimony given at arbitration hearings be made under oath?
c) Does the statute require that strict evidentiary rules be observed in the conduct of arbitration hearings?
d) Does the statute require that a transcript of the arbitration hearings be kept?
e) If the statute does not require the making of a transcript of the arbitration hearings, can the parties bring a reporter to the hearings to make a transcript?
f) Is the arbitrators' award final and binding on the parties to the arbitration?
g) Does the statute specify grounds for judicial review of arbitration awards?
h) Does the statute authorize the courts to hear de novo the subject matter of a controversy submitted to arbitration on which an award has been rendered?
i) Are there any peculiarities or noteworthy judicial constructions not analyzed under the foregoing questions?
j) Does any provision of the statute preclude its application to the resolution of personal injury claims?
k) Are there any reported cases indicating that the statute has been used to resolve personal injury claims?
l) Does the statute recognize the validity of agreements to submit existing as well as future disputes to arbitration?

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Can any conclusion be drawn as to whether the state's courts would recognize the validity of and give effect to arbitration awards resolving medical malpractice claims?

ALABAMA

I. STATUTORY FOUNDATION

Alabama has enacted an arbitration statute. *Ala. Code tit.* 7, Sections 829-844 (Recompiled 1958).

II. RELATIONSHIP OF STATUTE TO UAA

The Alabama Arbitration Statutes are older and less comprehensive than the UAA.

Sections 829 and 830 of the Alabama Statute provide that parties may arbitrate existing disputes rather than prospective controversies. But UAA Section 1 provides that parties may agree to submit both existing and prospective controversies to arbitration. Both the UAA and the Alabama Act require a written submission to arbitration.

Section 832 requires arbitrators to cause notification to the parties to be served not less than three days before the hearing, while UAA Section 5 requires that notice be served on the parties five days prior to the time and place of the hearing. Both Section 833 and UAA Section 4 allow a decision to be reached by a majority vote of the arbitrators.

Section 833 allows the arbitrators to fill a vacant arbitrator's post if the parties cannot agree to a replacement. In contrast, UAA Section 3 allows appointment by the court on application of a party when the parties are unable to agree on an arbitrator.

Section 834 provides for a more limited venue for application to the courts after an award is made than does UAA Section 18.

As with UAA Section 11 and Section 14, an award in Alabama has the force and effect of a judgment at law, upon which execution may issue. Section 834. UAA Section 9 permits three arbitrators to make changes in their award if an application therefor is made within 21 days by one of the parties. Alabama does not provide for such modification. Indeed under Alabama's arbitration provision, a party may seek court enforcement of an award if the other party has not performed 10 days after delivery of the award.

Alabama's Section 836 requires arbitrators to take an oath before they can validly discharge their duties. The UAA however does not require arbitrators to take an oath.

Both UAA Section 7 and Alabama's Section 837 empower arbitrators to subpoena witnesses, books, records and other documents and permit arbitrators to take depositions.

Alabama's arbitration provisions impose a specific penalty and liability for a duly summoned witness who fails to appear. Section 839.

Section 842 provides that an award can be set aside where partiality of the arbitrators in determining the award is shown. Similarly, UAA Section 12(2) looks more to whether there was evident partiality by an arbitrator appointed as a neutral when setting aside an award.

The Alabama statute provides for a more narrow scope of modification or vacation of arbitration awards than does the UAA. The UAA's section on modification, Section 13, requires Courts to correct an award where the arbitrators have made miscalculations and other minor errors. On the other hand, Alabama's Section 842 only authorizes Courts to modify or correct awards where arbitrators are guilty of fraud, partiality or corruption, and thus nonmerit errors might be sustained.

III. COMMON LAW ARBITRATION

While Alabama has statutory arbitration, Section 844 of the Act specifically provides that persons can continue to settle their disputes by common law arbitration.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

(a) The arbitrators, individually and collectively, have the power to subpoena witnesses, at the request of either of the parties, and must on application of either party issue commission to take the deposition of any witness residing out of the county. Section 837.

(b) Section 837 empowers arbitrators to administer all oaths which may be necessary in the progress of the submission.

There is no statutory requirement for swearing of witnesses. The Alabama courts have ruled that, in general, in an arbitration proceeding the rights of the parties and the duty and authority of the arbitrators are to be measured by the terms of the submission. *Anderson v. Miller*, 108 Ala. 171, 19 So. 302 (1895).

In *Gandy v. Tippett*, 155 Ala. 296, 46 So. 463 (1908), the court noted that a failure of the parties present at an arbitration proceeding to object to the fact that the parties were not sworn before testifying constituted a waiver of any right of objection.

(c) Both Alabama's arbitration provisions and case law are silent as to whether strict evidentiary rules are observed in arbitration proceedings.

(d) Alabama's statute is silent as to whether a transcript of the arbitration proceedings must be kept and there have been no Alabama court decisions requiring the making of a transcript.

(e) Alabama's statute and case law is silent as to whether the parties may agree to bring a reporter to the arbitration proceedings. However, it would seem that the parties could condition their agreement to arbitrate on the presence of a reporter at the arbitration proceedings or the making of a transcript of the proceedings.

(f) The certificate of arbitration, when filed with the circuit court clerk as provided by Section 834, has the force and effect of a judgment at law upon which execution may issue as in other cases. *Moss v. Upchurch*, 278 Ala. 615, 179 So. 2d 741 (1965).

An arbitration award has the conclusive effect of a judgment. *Yeatman v. Mattison*, 59 Ala. 382 (1877). Awards substantially complying with the statute are final and conclusive between parties and their privies as to the matter submitted unless the parties are guilty of fraud, partiality or corruption. *Fuerst v. Eichberger*, 224 Ala. 31, 38 So. 409 (1931).

(g) Section 842 provides that an award made in substantial compliance with requirements of the arbitration statute is conclusive as to matters submitted and cannot be inquired into or impeached for deficiencies of form or for irregularity, if the award determines the matter submitted. Such an award is final unless the arbitrators are guilty of fraud, partiality or corruption in making it.

As the Alabama courts have strictly construed the statute, they have narrowly construed grounds for judicial review of an arbitration award. In *Moss v. Upchurch*, 278 Ala. 615, 179 So. 2d 771 (1965), the Supreme Court of Alabama noted that there can be no retrial of issues passed upon by the arbitrators.

On the other hand, the arbitrators' award must conform to the submission. In *Flack-Beane Lumber Co. v. Bass*, 258 Ala. 255 (1952), the court pointed out that the arbitrators' jurisdiction or authority to act is derived from and limited by the arbitration agreement or submission which forms the basis for their awards. The Alabama Supreme Court asserted that the courts had the power to determine whether the award conformed to the submission agreement. In sum, any part of an award that does not conform to the submission is void. *Brown v. Mize*, 119 Ala. 10, 24 So. 453 (1898).

However, where there is a general submission of matters in controversy between parties, an award of a specified sum of money as due from one to the other would be sufficient on its face without reciting in detail the matters which were considered or decided. *Brewer v. Bain*, 60 Ala. 153 (1877).

(h) As previously indicated, the Alabama courts are willing to overturn an award only if it is shown that the award is the product of partiality, fraud or corruption. The statute and the cases do not explain what is to be done when an award is set aside on one of those grounds.

An Alabama federal district court decision indicates that when there is evidence of fraud or dishonest conduct in the processes which led to the arbitrators' decision, the courts can review the merits of the board's decision. *Parker v. Mercury Freight Lines, Inc.*, 307 F. Supp. 789 (N.D. Ala. 1969). However, in *Parker*, the court was not directly applying Alabama law and cited no Alabama cases in support of its opinion.

(i) Unlike most state arbitration statutes, Alabama specifically enacted its legislative policy to encourage settlement of disputes by arbitration. Section 829 provides that "It is the duty of all the courts to encourage the settlement of controversies pending before them by reference thereof to arbitrators . . . ."

(j) No provision in Alabama's arbitration statute makes it inapplicable to the settlement of personal injury claims.

(k) A review of the case law construing Alabama's arbitration provisions does not reveal any reported appellate court case where arbitration was used to settle a personal injury claim.

(l) Section 830 provides that when no suit is pending, parties to any controversy may refer the determination thereof to the decision of arbitrators. Section 831 provides that parties must concisely state the matters in dispute which they wish determined by the arbitrators. No provision allows parties to agree to submit future disputes to arbitration.

In *Headley v. Aetna Ins. Co.*, 202 Ala. 384, 385, 80 So. 466, 467 (1918), the Supreme Court of Alabama held that:

> A covenant in a contract, whether of insurance or of other matters, to submit every matter of dispute between the parties, growing out of such contract to arbitration . . . to the end of defeating the jurisdiction of courts as to the subject-matter, are universally held to be void, as against public policy.

While the Court emphasized the illegality of contract provisions purporting to require arbitration of future disputes, it recognized the validity of "Agreements . . . which merely provide a mode or manner for ascertaining the value of property, or the amount of damages, losses, or profits, are valid, and may be made conditions precedent to the right of action to recover damages based on such values, damages, losses or profits." *Headley v. Aetna Ins. Co., supra*, 202 Ala. at 385, 80 So. at 467.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there is no appellate authority recognizing the applicability of Alabama's arbitration statute to the resolution of personal injury claims, Section 830 provides that parties may submit "any controversy" to arbitration. This broad language would seem to indicate that the statute could be used to settle existing medical malpractice disputes. With regard to agreements to arbitrate medical malpractice disputes which might arise out of a contract, the statute's application would be limited to cases where liability is not contested and where damages alone are to be determined by the artibration. *Headley v. Aetna Ins. Co., supra.*

ALASKA

I. STATUTORY FOUNDATION

Alaska has recently enacted an arbitration statute. *Alaska Stat. Ann.* Section 09.43.010 through 09.43.180 (Cum. Supp. 1971) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The *Alaska Uniform Arbitration Act* is modeled after the *Uniform Arbitration Act.* It differs with the UAA in the following respects.

1) Section 09.43.010 (which corresponds to UAA Section 1) removes labor management contracts from the scope of the Act unless incorporated into the contract by reference.

2) Section 09.43.050 omits the phrase "The court on application may direct the arbitrators to proceed promptly with the hearing and determination of the controversy" found in UAA Section 5.

3) Although the language of Section 09.43.020 differs from its UAA Section 2 counterpart, it is in all material respects identical to UAA Section 2.

4) Section 09.43.120(a)(1) omits the word "corruption" found in UAA Section 12(a)(1). However the word "corruption" is included in Section 09.43.120(a)(2) as in UAA Section 12(a)(2).

5) In Alaska the "court of competent jurisdiction", UAA Section 17, is the superior court. Section 09.43.170.

6) The Alaska Act omits Sections 15, 18, 20, 21, 22 and 24 of the UAA.

III. COMMON LAW ARBITRATION

There are no reported appellate court cases indicating whether Alaska's court's recognize the validity of common-law arbitration.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 09.43.070(a) clothes arbitrators with the power to subpoena witnesses and books, records, documents and other evidence.

b) Section 09.43.070(a) empowers arbitrators to administer oaths but does not require that oaths be administered before taking evidence.

c) The Act does not indicate whether strict evidentiary rules are to be observed. However, Section 09.43.050(2) assures that parties are entitled to be heard, to present evidence and to cross-examine witnesses appearing at the hearing.

d) Although Section 09.43.080(a) states that "The award shall be in writing and signed by the arbitrators joining in the award" the Act is silent as to whether a transcript of the proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act does not prohibit an agreement between the parties to have a reporter at the arbitration proceedings. The case law gives no indication as to whether parties may agree to bring a reporter to the arbitration proceeding.

f) Except where the grounds for opposing an arbitration award exist under Section 09.43.120 or where the court declines to confirm an award on grounds other than those stated in Section 09.43.120(a)(5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

g) Grounds for judicial review of arbitration awards are substantially identical to those of the UAA, and are set forth in Section 09.43.120 (Vacating an award) and Section 09.43.130 (Modification or correction of award by court).

h) The Act does not provide for trial de novo of the subject matter of arbitration awards.

i) As previously indicated the Act is substantially identical to the UAA, and there are no peculiarities in the Act.

j) No provision in the Act precludes its application to the settlement of personal injury claims.

k) Although it would seem that the Act could be used to settle personal injury claims, no reported appellate court case indicates that it has been used in this manner.

l) Section 09.43.010 provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable, and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there is no reported appellate case law construing the provisions of Alaska's Arbitration Act, the fact that the Act is modeled after the UAA, and permits the arbitration of existing and future controversies, and provides for the resolution of "any controversy" by arbitration suggests that the Act would be applicable to the settlement of medical malpractice disputes.

ARIZONA

I. STATUTORY FOUNDATION

Arizona has enacted an Arbitration statute entitled The Arizona Arbitration Act. *Ariz. Rev. Stat. Ann.* Sections 12-1501 to 12-1517 (Supp. 1971) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The Arizona Arbitration Act is modeled after the UAA. It is substantially identical in most material respects to the UAA. Two notable dissimilarities between the statutes are:

1) Section 12-1517 limits the scope of the Act so that it is not applicable to arbitration agreements between employers and employees and their representatives;

2) The Arizona legislature omitted UAA Section 15 (Judgment Roll, Docketing) and Sections 19-15 (Appeals; Act not Retroactive; Uniformity of Interpretation; Constitutionality; Short Title; Repeal; Time of taking effect).

Other dissimilarities between the statutes are as follows:

1) Section 12-1501 omits the last sentence of UAA Section 1 (dealing with employer-employee disputes).

2) Section 12-1511 requires a party seeking confirmation of an award to file and save the application in the same manner as a civil action; judgment will be made on the award if opposition in accordance with Section 12-1512 is not made within 20 days of filing. However, UAA Section 12 allows 90 days to elapse before the judgment is made.

3) Section 12-1512(A) makes the filing of opposition (called vacating the award by UAA Section 12) a normal civil pleading and instructs the court to decline the award upon "an adequate showing" of any of its enumerated circumstances which are identical to UAA Section 12.

4) The Arizona Act omits Section 12(b) and Section 12(d) of the UAA, but these are largely supplemented by the additional provisions in Section 12-1511.

5) Section 12-1513(A) adds the phrase "if judgement has not been entered thereon" to UAA Section 13. Section 12-1513(D) adds a provision that if a judgment has been made the award is subject to the same power of the court as any other judgment which is subject to review under the state rules of civil procedure.

6) Section 12-1516 provides that the superior court is the appropriate court of jurisdiction. Venue provisions are the same as other civil actions. Section 12-1516 includes the provision of UAA Section 18 that all subsequent applications are made in the same court unless otherwise dictated.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Arizona courts have continued to recognize the validity of common law arbitration awards. *Gates v. Arizona Brewing Co.*, 54 Ariz. 266, 95 P.2d 49 (1939).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 12-507(A) clothes arbitrators with subpoena power. It states, in pertinent part, that "The arbitrators may cause to be issued subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence . . . ."

b) Section 12-507(A) empowers arbitrators to administer oaths but does not require that arbitrators administer oaths before taking testimony.

c) Section 12-1505(2) states that "The parties are entitled to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing." Beyond these safeguards, the Act is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

d) Although Section 12-1508(A) requires that "The award shall be in writing and signed by arbitrators joining in the award," the Act is silent as to whether a transcript of the arbitration proceeding must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act does not prohibit an agreement between the parties to have a reporter at the arbitration proceeding. The case law gives no indication as to whether parties may agree to bring a reporter or whether the parties customarily agree to bring a reporter to the arbitration proceeding.

f) Except where the grounds for opposing an arbitration award exist under Section 12-1512 or where the court declines to confirm an award on grounds other than those stated in Section 12-1512(A) (5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

In *Park Imperial, Inc. v. E.R. Tarmen Construction Co., Inc.*, 9 Ariz. App. 511, 454 P.2d 181 (1969), which involved an appeal from a superior court's (trial court) confirmation of a statutory arbitration award, the Court of Appeals determined that in absence of fraud or mistake or other provisions of Section 12-1512 the finding of the arbitrators is final. The Court noted that "Were the trial court required to try each case de novo the reason for arbitration agreements would be nugatory . . . ." *Park Imperial, Inc. v. E.R. Tarmen Construction Co., Inc., supra*, 454 P.2d at 183. Furthermore the appellate court stated that it must view the action of the trial court "in a light most favorable to upholding the trial court's determination . . . just as the trial court was required to view the arbitration award in a light most favorable to upholding the said award . . . ." *Park Imperial, Inc. v. E.R. Tarmen Co., Inc., supra*, 454 P.2d at 184-85.

g) Grounds for judicial review of arbitration awards are either similar or substantially identical to those of the UAA. Specifically, Section 12-1512 (Opposition to an award), Section 12-1513 (Modification or correction of award), and Section 12-1513(d) (providing that arbitration awards are subject to the powers of the court in the same manner as any other judgment which may be subject to review under Rule 60(c) of the Rules of Civil Procedure) set forth grounds for judicial review of arbitration awards.

h) The Act does not provide for trial de novo of arbitration cases. As previously noted in *Park Imperial*, were the courts required to try each case de novo the reason for arbitration would be nugatory. *Park Imperial, Inc. v. E.R. Tarmen Construction Co., Inc., supra*, 454 P.2d at 183. In sum, the notion of a trial de novo defeats the purpose of arbitration.

i) With exception of Section 12-1517 excluding the arbitration agreement between employers and employees from the scope of the Act, there are no other peculiarities in the statute.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

No provision in the Act precludes its application to the settlement of personal injury claims, and the Act has been used to settle such claims. Moreover, Section 12-1501 provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable, and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

Arizona is one of the jurisdictions within which there has been set up a joint screening panel, consisting of both attorneys and physicians (appointed by the local area's medical society and bar association) in Pima County, Arizona for the purpose of preventing the filing of court actions against a physician for professional malpractice in situations where facts did not permit at least a reasonable inference of malpractice. The process is initiated by filing with the panel a brief statement of facts (provided by the potential plaintiff and corroborated by the potential defendant), after which a hearing is called and the panel's medical experts testify in the presence of both parties. If the panel finds the evidence to be favorable to the patient's cause, then the medical society agrees to make an expert witness available to him at trial. If the panel finds no substantial evidence to support the alleged facts, the attorney is expected to refrain from filing suit. However, the provision establishing this Board hedges on this factor and the attorney is allowed to proceed to court if he is "personally satisfied that strong and overriding reasons compel such action." *See*, Lillard, *Arbitration of Medical Malpractice Claims*, 26 Arbit. L.J. 193 (1971).

It is clear that this screening panel issues merely an advisory opinion (compare with N.J. Provision, upheld in *Grove v. Seltzer*, 56 N.J. 321, 266 A.2d 301 (1970), containing an agreement for a binding option), attempting to provide a forum in which a problem may be aired and possibly resolved without the expense and publicity of a court proceeding. Whether the Arizona panel will subsequently follow the N.J. "binding option" plan (where the claimant is bound to drop his action in the event that his claim is determined by the panel to have no merit) is not clear from the data presently available with regard to the joint screening panel in operation in Pima County. *See* Lillard, *Arbitration of Medical Malpractice Claims, supra,* at 200-207.

As to the application of an arbitration agreement to malpractice claims, the State Attorney General has recently released a statement that the *Medical Malpractice Act. Ariz. Rev. Stat. Ann.* Section 32-1401 *et seq.* (Supp. 1971) does not prohibit a physician from entering into an agreement with a patient which requires malpractice claims to be submitted to arbitration. "Whether such a physician-patient arbitration agreement is legal is essentially a civil matter to be determined by appropriate judicial interpretation." *Op. Atty. Gen. No.* 70-4, at 11-12 (1970). And the Attorney General cited Section 12-1501, regarding the validity of arbitration agreements, as the applicable law enabling physicians and patients to agree to arbitrate medical malpractice disputes.

Moreover, prior to 1962 in addition to Arizona's statutory arbitration scheme, the Arizona courts recognized and enforced common law arbitration agreements with a patient which required malpractice claims to be submitted to arbitration. *Op. Atty. Gen. No.* 70-4.

As previously indicated, prior to 1962, Arizona recognized and enforced common law arbitration agreements, and the arbitration statute was not the exclusive means of arbitration recognized by the courts. *See Fineg v. Pickrell,* 81 Ariz. 313, 305 P.2d 455 (1957) (though the court stated that at common law, a general agreement to submit all disputes which may thereafter arise to arbitration is invalid and unenforceable as an attempt to oust the courts of jurisdiction). Yet it appears that under common law arbitration close judicial scrutiny (i.e. testing whether the subject matter of dispute was set out in such manner as to leave no reasonable doubt as to what was intended to be submitted to arbitration) is given any agreement to arbitrate. *Fineg v. Pickrell, supra,* 305 P.2d at 459.

Since the adoption of the UAA in 1962, arbitration has been used to settle personal injury claims. In *Baccus v. Farmers Ins. Group Exchange,* 12 Ariz. App. 1, 467 P.2d 76 (1970), *decision vacated on other grounds.* 106 Ariz. 280, 475 P.2d 264 (1970), the arbitrator awarded damages to the claimant under an arbitration clause for claims against the insurer arising from personal injuries caused by an uninsured motorist. Though the court stressed that the arbitrator's authority is circumscribed by the agreement from which his power to act is derived, the major issues under arbitration—whether the claimant was entitled to recover, and if so, in what amount—were held to be arbitrable issues. *Baccus v. Farmers, supra,* 467 P.2d at 77.

It thus appears that Arizona would be receptive to and would uphold valid arbitration agreements concerning claims for medical malpractice. While the *validity* of an agreement to arbitrate might be challenged on the basis of undue influence or adhesion, where a patient in immediate need of medical care is asked by a physician to sign an agreement to arbitrate, the courts would not vary an arbitration award which is contested on the *merits* of the controversy or upon the sufficiency of the evidence upon which the award is based. *See Funk v. Funk,* 6 Ariz. App. 527, 434 P.2d 529 (1967) (where court refused to modify the arbitration award concerning the sale of partnership assets in absence of a showing of fraud). In view of the Attorney General's opinion and the courts' favorable reception of arbitration agreements, the statute could be beneficially used to settle personal injury claims, including actions for medical malpractice.

ARKANSAS

I. STATUTORY FOUNDATION

Arkansas has enacted an arbitration statute. *Ark. Stat. Ann.* Sections 34-511 to 34-532 (Cum. Supp. 1972) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

In 1969, the Arkansas Legislature enacted its own Uniform Arbitration Act. Acts 1969, No. 260, Sections 1-24. With the enactment of the Act, Arkansas' former arbitration statute, *Ark. Stat. Ann.* Sections 34-501 to 34-510 (Repl. Vol. 1962), was repealed. Acts, 1969, No. 260, Section 24; See Compiler's Note following Act Section 34-532.

Although the Arkansas Act is modeled after and is substantially identical to the UAA, there is a critical dissimilarity. While UAA Section 1 recognizes the validity of written agreements to submit any existing controversy to arbitration and the validity of a provision in a written contract to submit any controversy arising out of the contract, the Arkansas Act expressly limits the application of its provisions to existing and future controversies arising out of a "contract for construction and/or manufacture", and specifically prohibits the application of the Act to *personal injury* or *tort* matters as well as employer-employee disputes and insured or beneficiary disputes with insurers. More specifically, Section 34-511 of the Act states:

> 34-511. Agreement to arbitrate—Exceptions—A written agreement to submit to arbitration any existing or future controversy arising out of a contract for construction and/or manufacture, is and shall be valid and enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract; provided, that *this act* (Sections 34-511—34-532) *shall have no application to personal injury or tort matters,* employer—employee disputes, nor to any insured or benefici-

> ary under any insurance policy or annuity contract. (Emphasis added).

The Arkansas Act also differs with the UAA in one minor respect:

1) UAA Section 22 (Constitutionality) and UAA Section 24 (Repeal) have not been codified in the Arkansas Act. However, Acts 1969 No. 260 Section 22 (Separability) and Section 24 (Repeal) are substantially identical to UAA Sections 22 and 24. These uncodified sections of Acts 1969 are noted after Section 34-532 and provide:

> Separability. Section 22 of Acts 1969, No. 260. "If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given without the invalid provision or application and to this end the provisions of this act are severable."

And Section 24 of Acts 1969, No. 260, in effect provided that all acts or parts of acts which are inconsistent with the provisions of this act are hereby repealed.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Arkansas courts have continued to recognize the validity of and give effect to common-law arbitration awards. *Alexander v. Fletcher*, 206 Ark. 906, 175 S.W.2d 196 (1943). However, while the Arkansas courts have held that statutory arbitration provisions supplement common law arbitration remedies, they have also held that where statutory arbitration was contemplated by the parties, failure to comply with the statute's requirements voids the arbitration award, and bars the affirmance of the award under the common law. *Franks v. Battles*, 147 Ark. 169, 227 S.W. 32 (1921).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 34-517(a) empowers arbitrators with the power to issue or cause to be issued subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 34-517(a) empowers arbitrators to administer oaths but does not require that arbitrators administer oaths before taking testimony.

c) Section 34-515(b) states that "The parties are entitled to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing." Beyond these safeguards, the Act is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

d) Although Section 34-518(a) requires that "The award shall be in writing and signed by arbitrators joining in the award" the Act in silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act is silent as to whether the parties may bring a reporter to the arbitration proceedings. However, it would appear that the parties could agree to submit a controversy to arbitration on the condition that a reporter be present or even that a transcript of the proceedings be kept by the arbitrators.

f) Except where the grounds for opposing an arbitration award exist under Sections 34-522 and 34-523 or where the court declines to confirm an award on grounds other than those stated in Section 34-522(a) (5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

g) Grounds for judicial review are substantially identical to those of the UAA. More specifically, Section 34-522 (Vacating an award) and Section 34-523 (Modification or correction of award) set forth grounds for judicial review of arbitration awards.

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Rather, where an award is rendered in compliance with all the Act's requirement, it is a final and binding determination of the issue submitted and precludes a de novo determination of that issue by a court or by a subsequent arbitration.

i) As previously indicated in the analysis of Question II, Section 34-511 severely limits the application of the Act. In this regard the Act is most peculiar as no other state enacting the UAA has so severely limited its application.

j) Section 34-511 expressly limits the application of the act to the resolution of personal injury claims. In pertinent part, it states that: " . . . this act (Sections 34-511—34-523) shall have no application to personal injury or tort matters,. . . ."

k) Although the Act has not spawned any case law, it is clear from the explicit prohibition of Section 34-511 that the Act cannot be used to resolve personal injury claims.

l) Section 34-511 expressly recognizes the validity of written agreements to submit existing and future controversies to arbitration. However, unlike UAA Section 1 which recognizes the validity of written agreements to submit *any controversy* to arbitration, Section 34-511 of the Arkansas Act expressly limits its application to a "controversy arising out of a contract for construction and/or manufacture."

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although the Arkansas Act has not yet spawned any case law construing its provisions, it is clear from the express command of Section 34-511 prohibiting the Act's application to personal injury or tort matters that the Act's usefulness for the resolution of medical malpractice claims is severely limited if not totally prohibited.

CALIFORNIA

I. STATUTORY FOUNDATION

California has enacted an arbitration statute. *Cal. Code Civil Proc.*, Sections 1280-1294.2 (West Cum. Supp. 1972) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

California has had an arbitration statute since 1851 and traditionally has been one of the states most sympathetic towards arbitration. Mendelson, *Arbitration: A Review and Perspective–1966*, 41 Cal. Bar J. 494, 495-96 (1966).

The current Act embodies fundamental changes recommended by the California Law Review Commission in 1961. 3 Cal. Law Revision Comm., *Arbitration: Recommendation and Study*, G-5, G-25 (1961). Although the revised Act is not modeled after the UAA, the substantive provisions of the UAA are embodied in it. Furthermore, the Act is even more detailed and thorough than the UAA in setting forth procedural mechanisms.

One of the most significant dissimilarities between the California Act and the UAA is the development by the California Act of a "neutral arbitrator", defined by the Act as:

" . . . an arbitrator who is (1) selected jointly by the parties or by the arbitrators selected by the parties or (2) appointed by the court when the parties or the arbitrators selected by the parties fail to select an arbitrator who was to be selected jointly by them." Section 1280 (d).

Section 1282 of the Act details the exercise of the powers and duties of a neutral arbitrator; this section applies unless the arbitration agreement provides otherwise. Most importantly, Section 1282 states:

> Unless the arbitration agreement otherwise provides, or unless the parties to the arbitration otherwise provide by an agreement which is not contrary to the arbitration agreement as made or modified by all of the parties thereto:
>
> (a) *The arbitration shall be by a single neutral arbitrator.* (Emphasis added).

In addition to the neutral arbitrator the California Act has retained the usual party-appointed arbitrator. If a party does not appoint an arbitrator, or if the parties or their appointed arbitrators cannot agree on a neutral arbitrator, the court will appoint either class of arbitrator to fill the void. However, the Act distinguishes between the appointment of an arbitrator and a neutral arbitrator. Section 1281.6. The powers of a neutral arbitrator are elaborated in Section 1282.2 and these closely parallel the powers conferred on arbitrators by UAA Section 5.

Among the significant provisions of the California Act not found in the UAA are those of Section 1283.05 which specify the manner for taking depositions and obtaining discovery in arbitration proceedings. Perhaps most noteworthy of these is Section 1283.1(a). This incorporates the provisions of Section 1283.05 which sets forth the parties' rights to take depositions and to obtain discovery with regard to controversies arising out of any injury to a person caused by the wrongful act or neglect of another. More specifically, Section 1283.1(a) provides:

> All of the provisions of Section 1283.05 shall be *conclusively deemed to be incorporated into, made a part of, and shall be applicable to, every agreement to arbitrate any dispute, controversy or issue arising out of or resulting from any injury to or death of, a person caused by the wrongful act or neglect of another.* (Emphasis added).

In contrast to the broad language of UAA Section 1 which specifies the scope of the Act's application, Section 1283.1(a) of the California Act, in effect, specifically recognizes the validity of arbitrating medical malpractice disputes.

Further differences between the California Act and the UAA are indicated below.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the California courts have continued to recognize the validity of common law arbitration. *Utah Const. Co. v. Western Pac. Ry.*, 174 Cal. 156, 162 P. 631 (1917).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 1282.6 empowers the neutral arbitrator to issue subpoenas for the attendance of witnesses and subpoenas duces tecum for the production of books, records, documents and other evidence. This Section is substantially identical to UAA Section 7(a) except that the California Act gives the powers to the neutral arbitrator while the UAA gives it to "the arbitrators."

b) Section 1282.8 empowers the neutral arbitrator to administer oaths but does not require that oaths be administered before taking evidence. However, Section 1282.2(d) in part provides that "On request of any party to the arbitration, the testimony of witnesses shall be given under oath."

c) Unlike the UAA which is silent as to whether the arbitration proceedings are to be conducted in accordance with strict evidentiary rules, the California Act expressly provides that rules of evidence need not be observed in the conduct of arbitration hearings. More specifically, Section 1282.2(c) states:

> The neutral arbitrator shall preside at the hearing, shall rule on the admission and exclusion of evidence and on questions of hearing procedure and shall exercise all powers relating to the conduct of the hearing.

And, Section 1282.2(d), which, like UAA Section 5(b), guarantees the parties the right to be heard, present evidence and cross-examine witnesses, states in part:

> The parties to the arbitration are entitled to be heard, to present evidence and to cross-examine witnesses appearing at the hearing, *but*

> *rules of evidence and rules of judicial procedure need not be observed.* (Emphasis added).

Moreover, in *Firestone Tire & Rubber Co. v. United Rubber Workers of America, Local Union No. 100, AFL-CIO*, 168 Cal. App. 2d 444, 335 P.2d 990 (1959), the Court pointed out that arbitrators are not bound to strict adherence to legal procedures and are not required to make findings of fact or give reasons for their awards.

d) Although Section 1283.4 requires that "The award shall be in writing and signed by the arbitrators concurring (in the award)," the Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript. On the other hand, it should be recognized that Section 1282.2(c) empowers the neutral arbitrator to "exercise all powers relating to the conduct of the hearing." Thus, unless the arbitration agreement otherwise provides, it would seem that this broad authorization could include the power of the neutral arbitrator to cause a transcript of the proceedings to be kept.

While it would appear that the parties or the neutral arbitrator could cause a transcript to be kept, the absence of any provision requiring that a transcript be kept could be explained by the fact that the California courts are very reluctant to overturn the decision of the arbitrators. Not only have the Courts consistently recognized that the purpose of enacting a comprehensive statutory scheme for arbitration is to encourage resort to arbitration, but they have emphasized their own limited role in reviewing arbitration awards. In *Frantz v. Inter-Insurance Exchange of Auto. Club of So. Cal.*, 229 Cal. App. 2d 269, 40 Cal. Rptr. 218 (1964), the Court demonstrated its limited review role in an appeal from an award of damages to an injured party resulting from an accident with an uninsured motorist. In addition to saying that the arbitrators need give no findings or reasons for the award, the Court asserted that it could not review the merits of the dispute or the sufficiency of the evidence which supported the award. Rather, as the court pointed out, it was limited to vacating, modifying or correcting an award where fraud or other statutory grounds are asserted by the complaining party.

e) The Act and case law are silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings.

f) Except where grounds for opposing an arbitration award exist under Sections 1286.2 and 1286.4, the arbitration is final and binding upon the parties upon entry of judgment pursuant to Section 1286. *See* Section 1286 for the time for service and filing an award.

Moreover, unlike the UAA, the California section strengthens unconfirmed awards by making it clear that they are binding as contracts even after the time for seeking judicial confirmation (4 years, under Section 1288) has expired. Section 1287.6. And see *Doyle v. Giuliucci*, 62 Cal. 2d 606, 401 P.2d 1, 43 Cal. Rptr. 697 (1965); *Jones v. Kvistad*, 19 Cal. App. 3d, 97 Cal. Rptr. 100 (1971).

g) Grounds for judicial review are in substance similar to those of the UAA and are set forth specifically in Sections 1286.2 and 1286.6.

As previously indicated in the analysis of Question IV (c), the findings of the arbitrators on questions of fact are final and conclusive and are not subject to judicial review, except for (1) fraud, corruption, (2) prejudicial misconduct in procedural matters by the arbitrators, (3) imperfect execution in the making of the award so that it is not "Final and definite" as required or (4) exercise of powers by the arbitrators which are in excess of their authorization. *Olivera v. Modiano-Schneider, Inc.*, 205 Cal. App. 2d 9, 23 Cal. Rptr. 30 (1962).

Finally, it should be noted that the California courts have held that before they will vacate or modify an arbitration award, the complaining party must affirmatively show that the arbitrator, in reaching the award, not only committed an error, but he must also show that the error had substantially prejudiced his case. *Turner v. Cos*, 196 Cal. App. 2d 596, 16 Cal. Rptr. 644 (1961).

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. The California courts have repeatedly held that the merits of an arbitration controversy are not subject to judicial review except as provided in the Act. Where an award is vacated, Section 1287 provides that:

> [T]he court may order a rehearing before new arbitrators. If the award is vacated on the grounds set forth in subdivision (d) or (e) of Section 1286.2, the court with the consent of the parties to the court proceeding may order a rehearing before the original arbitrators.

i) The California Act is unusual in explicitly providing for the resolution of personal injury claims and establishing a mechanism whereby the parties to a personal injury arbitration can obtain discovery. Perhaps the presence of a provision expressly recognizing the validity of the resolution of personal injury claims by arbitration under the Act can be explained by other provisions of the Code. *Cal. Insurance Code*, Section 11580.2 (West 1972) provides that damages from accidents involving an uninsured motorist shall, in the event of disagreement between the parties, be determined by arbitration. Pursuant to this provision, in 1966, there were a total of 2,100 of these arbitration cases in Los Angeles. Mendelson, *Arbitration: A Review and Prospective–1966*, 41 Cal. Bar J. 494 at 501 (1966); And See *Frantz v. Inter-Insurance Exchange of Auto. Club of So. Cal.*, 119 Cal. App. 2d 269, 40 Cal. Rptr. 218 (1964).

j) As noted previously, Section 1283.1(a) expressly provides that personal injury claims may be arbitrated under the Act. Moreover, the Act seems designed to encourage the resolution of personal injury claims by arbitration.

k) The Act has been used to resolve personal injury claims, and the California courts have recognized the validity and given effect to awards resolving such claims. See, e.g., *Calhoun v. State Farm Mut. Auto Ins.*

Co., 254 Cal. App. 2d 407, 62 Cal. Rptr. 177 (1967); see Mendelson, *supra.*

In *Doyle v. Giuliucci*, 60 Cal. 2d 606, 43 Cal. Rptr. 697, 401 P. 2d 1 (1965), the Supreme Court of California confirmed an arbitration award involving a medical malpractice claim and held that a contract for family health care between an infant's father and a medical group which provided for arbitration of claims arising thereunder was binding on the minor.

1) Although predecessor provisions of California's arbitration Act prohibited agreements to submit to arbitration controversies arising out of contracts and declared such agreements void as against public policy, *Loving & Evans v. Blick*, 33 Cal. 2d 603, 204 P. 2d 23 (1949), Section 1281 of the Act expressly provides that a contract to submit existing and future disputes to arbitration is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the rev ocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

The Supreme Court of California's holding that medical malpractice disputes arising out of a contract for medical and surgical services may be submitted to arbitration under the Act, and that such agreements which are made by parents bind children to arbitrate any dispute arising thereunder, confirms the Act's applicability to the resolution of existing and future medical malpractice disputes. *Doyle v. Giuliucci*, 60 Cal. 2d 606, 43 Cal. Rptr. 697, 401 P. 2d 1 (1965).

COLORADO

I. STATUTORY FOUNDATION

Colorado has enacted an arbitration statute. *Colo. Rev. Stat. Ann.* Ch. 18, Rule 109 (1963) (hereinafter Rule 109).

II. RELATIONSHIP OF STATUTE TO UAA

Colorado's arbitration Rule 109 is not based upon nor related to the UAA. Dissimilarities between the UAA and Rule 109 are indicated in the analysis of "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Colorado courts have continued to recognize the validity of common law arbitration. *Ezell v. Rocky Mt. Bean & Elevator Co.*, 76 Colo. 409, 232 P. 680 (1925).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Rule 109(d) clothes the arbitrators with the power to subpoena witnesses. In pertinent part, Rule 109(d) states that "Arbitrators shall have power to issue subpoenas for witnesses."

b) As a matter of practice testimony is made under oath. However, testimony need not be made under oath. Rule 109(d) empowers arbitrators to administer oaths, but does not mandate that arbitrators administer oaths to witnesses.

On the other hand, Rule 109(c) prohibits arbitrators to act without first subscribing to an oath.

c) So long as arbitrators conform to the requirements of Rule 109 and hearings are fairly conducted, arbitrators are not bound to strict evidentiary rules.

Sisters of Mercy of Colorado v. Meade & Mount Const. Co., 165 Colo. 147, 439 P.2d 733 (1968), stands for the proposition that "strict adherence to legal punctilio" in arbitration proceedings is not judicially required. In *Sisters*, the Supreme Court of Colorado refused on a writ of error to interfere with the arbitration award in spite of alleged technical irregularities. The Court stated that where parties freely consent to and participate in arbitration, no claim of fraud or mistake is alleged, and hearings are fairly conducted, technical irregularities in the conduct of the arbitration proceedings are insufficient to upset an arbitration award.

d) It does not appear that Colorado requires that a formal transcript be provided to the parties, or that a transcript of the proceeding be kept. Yet the arbitrators, after the hearing, are required under Rule 109(e) to set forth their findings and decision in writing at the close of the proceeding, setting out the matters in controversy and the basis for their findings. (An example of such findings is printed in part in *Sisters of Mercy of Colorado v. Meade & Mount Const. Co., supra*, 439 P.2d at 735).

In *Twin Lakes Reservoir & Canal Co. v. Platt Rogers*, 112 Colo. 155, 147 P.2d 828 (1944), the arbitration board received consultation from a private legal advisor concerning an issue whether interest was allowable in the arbitration award. The court found no error nor any duty that the arbitrators furnish the parties reports of the legal consultation with this private legal advisor who had been recommended to the board by both parties. *Twin Lakes, supra*, 147 P.2d at 835.

e) The statutory language of Rule 109 neither prohibits nor authorizes the parties to bring reporters to their arbitration proceedings. Moreover, just as Rule 109 is silent as to the permissibility of reporters at arbitration proceedings so is the case law construing Rule 109.

f,g,h) Rule 109(e) provides that the arbitrators' award may be filed in the district court where the matters were arbitrated and that the district court shall enter judgment on the award where the arbitration proceedings have been conducted in accordance with the procedures of Rule 109.

Rule 109(g) provides that as to the subject matter of the proceedings the award of the arbitrators is final and binding on the parties, and such subject matter is not subsequently open, either directly or indirectly, to judicial review. However, Rule 109(g) does not:

> . . . [P]revent an adjudication by arbitrators from being impeached or set aside for fraud or other sufficient cause . . . nor to prohibit relief on the gounds of mistake, inadvertence, surprise, or excusable neglect. . . .

The Colorado courts have given favorable treatment to arbitration and view it as a convenient and efficient method of settling disputes. *Twin Lakes* and *People ex rel. Kimball v. Crystal River Corp.*, 131 Colo. 163, 280 P.2d 429 (1955), have both held that arbitrators are the final judges of both law and fact, and that an award will not be reviewed because of mistakes by the arbitrator as to either law or fact.

Recently, a federal district court reviewed the Colorado law with regard to the review of arbitration awards made pursuant to Rule 109 and found that mistake in either fact or law is insufficient ground to overturn an arbitration award. Rather, the federal court concluded that under Colorado law only fraud or misconduct of the arbitrators are sufficient grounds for setting aside an arbitration award. *Gladdis Mining Co. v. Continental Materials Corp.*, 196 F. Supp. 860 (D. Colo. 1961).

In *Gladdis*, where an arbitration award for recovery of a debt from a purchase agreement was upheld, the federal court emphasized that the arbitrators are the final judges of law and fact and that it would not substitute its judgment for that of the arbitrators. Particularly significant was the fact that the Court gave special deference to the determination of a "highly scientific problem on which experts alone are qualified to make a determination." *Gladdis, supra*, 196 F. Supp. at 866.

In sum, absent a showing of bad faith or fraud, the arbitrators' determination is final as to the subject matter decided and not subject to review.

What the Colorado courts do require in arbitration is: (1) elemental fairness to the parties; (2) proper jurisdiction over the subject matter to be arbitrated; and (3) that the award of the arbitrators represent the conclusion of the arbitrators themselves (i.e., the arbitrators may not delegate their responsibilities to an outsider and blindly adopt the conclusion of a third party). See generally, *Twin Lakes, supra*, 147 P.2d at 832.

i,j,k) Although this research has disclosed no reported appellate court case where Rule 109 has been used to arbitrate a personal injury claim, there appears to be no language in the statute which would bar its usage in such a manner. At present, the use of arbitration has been sanctioned by statute for use in fair labor practices (*Colo. Rev. Stat. Ann.* Section 80-4-10 [1963)], killings of live stock by railroads (*Colo. Rev. Stat. Ann.* Section 116-8-11 [1963)], and various other contract arrangements. Rule 109(a) provides that all controversies which may be the subject of a civil action may be submitted to arbitration, subject to limitations set out in Rule 109. Thus an arbitration award settling medical malpractice claims would likely be given full credit by the Colorado courts.

l) It would appear that since Rule 109(a) provides that all controversies which may be the subject of a civil action may be submitted for arbitration, existing and future disputes could be arbitrated under Rule 109.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

As previously stated, Rule 109(a) provides that all controversies which may be the subject of a civil action may be submitted to arbitration. Since medical malpractice claims are civil actions, it would appear that malpractice claims could be arbitrated under Rule 109.

CONNECTICUT

I. STATUTORY FOUNDATION

Connecticut has enacted an arbitration statute. *Conn. Gen. Stat. Rev.* Sections 52-408 to 52-424 (1958 & Cum. Supp. 1972).

II. RELATIONSHIP OF STATUTE TO UAA

Although the Connecticut arbitration statute is not modeled after the UAA it is similar to it in most substantive respects. Dissimilarities between the two acts are indicated in the analysis of the "Procedural Attributes of the Statute." (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, Connecticut's courts have continued to recognize the validity of common law arbitration awards. *Yale & Towne Mfg. Co. v. International Association of Machinists*, 15 Conn. Sup. 118 (1947).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 52-412 empowers arbitrators to issue subpoenas for the attendance of witnesses and for the production of books, papers and other evidence.

b) Section 52-414 empowers arbitrators to administer oaths to witnesses but does not require that oaths be administered before taking evidence.

Unlike the UAA, arbitrators must be sworn before hearing the controversy submitted to arbitration unless the oath is waived in writing by the parties to the arbitration agreement. Section 52-414. See also *Textile Workers Union v. Uncas Printing & Finish Co.*, 19 Conn. Sup. 385, 115 A.2d 473 (1955).

c) The Connecticut statute is silent as to whether arbitration proceedings must be conducted in accordance with strict evidentiary rules. However, the Connecticut courts have held that arbitrators are not bound to follow strict rules of evidence, unless it be made a condition of the submission. *Chase Brass & Copper Workers Union Local 1565*, 139 Conn 591, 96 A.2d 209 (1953).

In *Gores v. Rosenthal*, 150 Conn. 554, 192 A.2d 210 (1963), the Supreme Court of Connecticut emphasized that "arbitration" is the voluntary submission by interested parties of an existing or future dispute to a disinterested person or persons for final determination which is intended to avoid the formalities, delay, expense and vexation of ordinary litigation. See also *Liggett v. Torrington Bldg. Co.*, 114 Conn. 425, 158 A. 917 (1932).

d) Although Section 52-416 (Cum. Supp. 1972) requires that "The award shall be in writing and signed by the . . . arbitrators, or a majority of them," the statute is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript. See generally *Von Lagendorff v. Riordan*, 147 Conn. 524, 163 A.2d 100 (1960) (where the Court held that an arbitration award must contain the actual decision but need not make findings of fact).

Furthermore, Section 52-421, which lists the papers to be filed with the clerk when any party applies for an order confirming, modifying or correcting an award, does not require the filing of a transcript and, in fact, is silent as to the existence of a transcript.

e) The Connecticut statute is silent as to whether the parties may agree to bring a reporter to the arbitration proceedings. It would appear, however, that the parties could condition their agreement to arbitrate on the presence of a reporter or even the making of a transcript just as the parties could provide in their agreement that the arbitrators will conduct the hearings in accordance with evidentiary rules of law. *See Uncas Printing, supra.*

f) Except where the grounds for opposing an arbitration award exist under Sections 52-418 and 52-419, the arbitration award is final and binding on the parties upon entry of judgment or decree by the court pursuant to Section 52-417. *International Union, United Auto. Aerospace, etc. v. Fafnir Bearing Co.*, 151 Conn. 650, 201 A.2d 656 (1964). Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award. *Von Langendorff v. Riordan*, 147 Conn. 524, 163 A.2d 100 (1960).

g) Grounds for judicial review are similar to those of the UAA. More specifically, Section 52-418 (Vacating award) and Section 52-419 (Correction of award) set forth grounds for judicial review of arbitration awards.

In *Gray Excavating Co. v. Town of North Haven*, 160 Conn. 411, 279 A.2d 543 (1971), a controversy arose from a claim by plaintiff-contractor that it was required to incur unanticipated additional expense in building the town's sewers due to subsoil conditions which differed from those contained in the information submitted to it for the purpose of preparing its bid. As provided by the contract, the contractor submitted its claim to arbitration, and the arbitrators found that discrepancies existed between the information and the actual soil conditions and that the discrepancies caused the contractor to incur additional expenses.

After the arbitrators awarded the contractor additional compensation for the cost overruns, the contractor, as permitted by Sections 52-418 and 52-419, filed in the Superior Court an application to vacate "and/or" correct the arbitration award. The Superior Court concluded that the award was ambiguous, improperly executed and not final and entered a judgment vacating the award. Defendants, town and sewer commission, appealed.

In examining the submission and the award to determine whether the award was in conformity with the submission so as to constitute a mutual, final and definite award upon the subject matter submitted, the Supreme Court of Connecticut stated the controlling principles of law as follows:

> . . . 'It is the established policy of the courts to regard awards with liberality. Every reasonable presumption and intendment will be made in favor of the award and of the arbitrators' acts and proceedings. Hence, the burden rests on the party attacking the award to produce evidence sufficient to invalidate or avoid it.' [Citation omitted]. The arbitrators are only required to render an award in conformity to the submission and an award need contain no more than the actual decision of the arbitrators. The means by which they reach the award, unless the submission requires, is needless and superfluous. [Citation omitted].

Gary Excavating Co. v. Town of North Haven, supra, 160 Conn. at 413-414, 279 A.2d at 545-546.

Applying these principles of law, the Court reversed the judgment setting aside the award and remanded the case with the direction that the award be confirmed. In so holding the Court stated:

> The submission in this case was a narrow and limited one. The questions submitted were answered by the award with precision and definiteness. The arbitrators found that discrepancies did exist between the information furnished by the defendants concerning subsoil conditions and conditions actually encountered in the course of the work, and that the plaintiff had proved by the evidence submitted to the arbitrators that as a result it had incurred additional expense in the amount of $150,000. That is the sum which the arbitrators awarded. Nothing more was required by the submission. If the plaintiff had further or other claims or questions for decision they should have been included in the submission. As it stands the award is a definite answer to the claims as submitted and we find nothing in the record to support the contrary conclusion of the trial court that the award was ambiguous, indefinite or improperly executed.

Gary Excavating Co. v. Town of North Haven, supra, 160 Conn. at 414, 279 A.2d at 545-546.

h) The Connecticut statute does not provide for a trial de novo of the subject matter of the arbitration. Rather, an award made in compliance with the statute's provisions and confirmed by the court is final and binding on the parties.

i) The Connecticut arbitration statute has two noteworthy provisions which have not been analyzed herein.

Section 52-415 sets forth a procedure whereby the arbitrators, upon the written request of all the parties to the arbitration, may request a court to decide any question arising in the course of the arbitration hearing. Where the court determines a question pursuant to this procedure, it is binding on the arbitrators, and their award must be made in compliance with the court's determination.

Section 52-416 (Cum. Supp. 1972) nullifies any award which is not made within thirty days from the date the hearings are completed where the parties have not fixed in their arbitration agreement a time within which an award is to be rendered. The time period can, however, be extended by written agreement of the parties.

j) No provision of the statute precludes its application to the resolution of personal injury claims.

k) The Connecticut statute has been used to resolve personal injury claims.

In *Kilby v. St. Paul Insurance Co.*, 29 Conn. Sup. 22, 269 A.2d 295 (1970), the Suprior Court of Hartford County confirmed an award rendered pursuant to the arbitration clause of the uninsured motorist provisions of a policy issued by defendant-insurer.

Plaintiff-insured demanded arbitration against her losses by reason of her personal injuries sustained in an accident with an uninsured motorist. Although the provisions of the uninsured motorist clauses stated that the issues of liability and damages would be arbitrated, the arbitrator made the following award: "The St. Paul Insurance Company shall pay to Charlene Kilby the sum of . . . ($2,350.00)," which was clearly outside the scope of the submission.

Because the award went beyond the submission, the insurer motioned to vacate, modify or correct the award pursuant to Sections 52-418 and 52-419. While recognizing that the insured presented a statutory ground for vacating the award, the Court nevertheless rejected insurer's motion:

> . . . [A] motion must be made, however, not later than "thirty days from the notice of the award to the party to the arbitration who makes the motion." General Statutes Section 52-420. If a motion to vacate, modify or correct is not made within the thirty-day time limit, the award may not thereafter be attached on any of the grounds specified in Sections 52-410 and 52-419. *Local 1078 United Auto, Aircraft and Agr. Implement Workers of America UAW-CIO v. Anaconda American Brass Co.*, 149 Conn. 687, 691, 183 A.2d 623; *Textile Workers Union v. Uncas Printing & Finishing Co.*, 20 Conn. Sup. 91, 97, 125 A.2d 236. The defendant has not moved to vacate, modify or correct the award on any of the grounds specified in those statutes, or on any others.
>
> Therefore, even though the award was outside the submission, the court cannot now base a denial of the motion to confirm on that ground. *See Textile Workers Union v. Uncas Printing & Finishing Co., supra*, 98, 125 A.2d 236. . . .

Kilby v. St. Paul Insurance Co., supra, 269 A.2d at 296-297.

1) Section 52-408 provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract. *Dewart v. Northeast Gas Transmission Co.*, 140 Conn. 446, 101 A. 2d 299 (1954).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given (1) the resolution of personal injury claims under the statute, (2) the broad language of Section 52-408 which states that "any controversy" may be submitted to arbitration and (3) the legislative and judicial policy favoring arbitration, it would appear that medical malpractice claims could be arbitrated under Connecticut's Act.

DELAWARE

I. STATUTORY FOUNDATION

Delaware has enacted an arbitration statute. *Del. Code Ann.* Tit. 10, Sections 5701-5706 (1953).

II. RELATIONSHIP OF STATUTE TO UAA

The Delaware arbitration statute is a direct descendant of an 1852 act. It is markedly dissimilar from the UAA. The Delaware statute does not assure the parties of procedural safeguards such as the right to be represented at a proceeding, guaranteed under the UAA. Moreover, the referees are not delegated any judicial powers. Finally, the detail of the UAA providing for the change of award by arbitrators, the procedure to compel or stay arbitration, and the procedure and grounds for vacating, modifying and correcting an award are absent from the Delaware arbitration statute.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Delaware courts have continued to recognize the validity of common law arbitration. *See Electrical Research Products v. Vitaphone Corp.*, 20 Del. Ch. 417, 171 A. 738 (1934).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) The Delaware arbitration statute does not empower referees to issue subpoenas for the attendance of witnesses or for the production of books, records, documents and other evidence.

b) The Delaware arbitration statute does not empower referees to administer oaths. The statute and case law are silent as to whether witnesses testifying before referees are under oath.

While the statute is silent as to the administration of oaths to witnesses at arbitration hearings, the statute specifically requires court-appointed referees to take an oath. Section 5704 in part provides:

> Each referee, named in a rule of reference, shall before signing a report, be duly sworn, or affirmed, to determine the matters in controversy faithfully and impartially . . . .

Failure to swear the referees invalidates the award. *Stewart v. Grier*, 7 Houst. 378, 12 Del. 378, 32 A. 328 (1886). Moreover, court-appointed referees who refuse or neglect to perform their duties can be punished by a fine of not more than $10 by the court. Section 5703.

c) The Delaware arbitration statute is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

d) The Delaware arbitration statute is silent as to whether a transcript of the arbitration proceedings must be kept. The statute only requires that an award or report of the referees be made where it is to be approved by the court. Sections 5705, 5706.

e) The statute and case law are silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings or even on the keeping of a transcript.

f) The referees' award is not final and binding upon the parties until the award is approved by the court. Section 5706 in pertinent part provides that "The award or report of referees, being approved by the court, shall be available in law as the verdict of a jury." And Section 5706 states, with regard to reports by court-appointed referees, that "The report of refereees upon a reference made under this chapter, being approved by the court, shall not be reversed upon appeal or a writ of error for want of . . . any . . . defect, . . . in the proceedings had in such action." *See Martindale v. Bowers Beach Corp.*, 13 Del. Ch. 288, 118 A. 299 (1922).

Where an award is not approved by the court and an action on an award is subsequently brought by the party who received the award, the plaintiff must establish that the parties agreed to: (1) submit their disputes to arbitration; and (2) abide by the arbitrators' award. Furthermore, the plaintiff must establish that the arbitrators were chosen in accordance with their agreement and that their award was made in accordance with their agreement. *Fooks v. Lawson*, 1 Marv. 115, 15 Del. 115, 40 A. 661 (1898).

g) Although the Delaware arbitration statute does not set forth grounds for judicial review, the Delaware courts have reviewed and vacated arbitration awards on several grounds.

As a general rule, the Delaware courts have held that a referee's finding is binding where it is supported by the evidence and that such a finding would not be disturbed by the court. *Phoenix Oil Co. v. Mackenzie Oil Co.*, 34 Del. 460, 154 A. 894 (1931); *Omar Oil & Gas Co. v. Mackenzie Oil Co.*, 33 Del. 259, 138 A. 392 (1926). On the other hand, the Delaware courts have stated that they will correct a clear mistake of law or fact. *Allen v. Miles*, 4 Har. 234, 4 Del. 234 (1845).

In *Bailey v. England*, 17 Del. 12, 39 A. 455 (1897), the Court declared that arbitration awards would be set aside where the decision is so plainly or grossly against law that the award appears to be the product of fraud or partiality. And the Delaware courts have set aside arbitration awards where arbitrators have received evidence other than at the hearing. *Jessup & Moore Paper Co. v. A.S. Reed & Bro. Co.*, 10 Del. Ch. 146, 87 A. 1011 (1913). Finally, the Delaware courts have required that sufficient notice of a hearing be given to a party to the arbitration proceedings. *See Cazier v. Blackstone*, 1 Har. 362. 1 Del. 362 (1834).

h) There is no trial de novo of the subject matter of the controversy decided by the referee. Questions of fact are decided by the referee, and his findings will not be disturbed by a court if supported by evidence of probative value.

i) The Delaware arbitration statute, which is substantially identical to its 1852 predecessor, is peculiar in that it is silent as to procedures for conducting a hearing, compelling or staying arbitration, amending an award by the arbitrators and vacating, correcting and modifying an award by the court.

j) No provision of the statute prohibits its application to the resolution of personal injury claims.

k) Although it would appear that personal injury claims could be resolved by arbitration under the statute, there have been no reported appellate court cases where such a claim has been settled under the statute.

l) Section 5701, entitled "Reference of controversies," by its terms is only applicable to existing disputes between parties. In pertinent part, it provides: "In any action, the matters in controversy . . . may, by consent of the parties . . . , and a rule of the court, be referred . . . to . . . referees . . . ."

With regard to agreements to submit disputes arising out of a contract the Delaware court stated that such an agreement could not bar an action in court brought by one of the parties since the courts cannot be ousted of jurisdiction by the parties' agreements. *Randel v. Chesapeake & Del. Canal Co.*, 1 Har. 233, 1 Del. 233 (1833).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although in its long history there have been no reported appellate cases indicating that the Delaware arbitration statute has been used to resolve personal injury claims, and although the statute is void of procedural guidelines for the conduct of arbitration hearings, it would nevertheless appear that medical malpractice claims could be arbitrated under Delaware's Act.

DISTRICT OF COLUMBIA

I. STATUTORY FOUNDATION;
II. RELATIONSHIP OF STATUTE TO UAA;

III. COMMON LAW ARBITRATION: AND
IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

Congress has not enacted a comprehensive arbitration statute for the District of Columbia. Rather, Congress has ratified a single provision which provides for arbitration in the District of Columbia. *D.C.C.E.*, Section 11-1322 (Supp. 1972).

The arbitration provision, which is part of a chapter of the Code entitled "Small Claims and Concilliation Branch of the Superior Court," involves the reference of disputes to the District's judicial system. Section 11-1321 gives the Small Claims Court exclusive jurisdiction of claims involving the recovery of money if the amount in controversy does not exceed $750, exclusive of interest, attorney fee, protest fees and cost.

Arbitration is available only through a judge. Section 11-1322 states:

> In order to effect the speedy settlement of controversies, and with consent thereto, the Small Claims and Conciliation Branch may settle cases, irrespective of the amounts involved, by the methods of arbitration and conciliation. A *judge* sitting in the Branch may act as a referee or arbitrator, either alone or in conjunction with other persons, as provided by rule of the court. A judge, officer, or employee of the Superior Court may not accept any fee or compensation in addition to his salary for services performed pursuant to this section. [Emphasis added.]

The effect and application of this provision are obscured by the fact that there have been no reported cases under the present statute or its predecessor.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although Congress has enacted an arbitration provision for the District of Columbia, it is incomplete, and, judging from the absence of case law, it would appear that arbitration under this narrow statute is not conducive to the settlement of controversies. The arbitration provision which consists of a single paragraph is silent as to procedural mechanisms for conducting hearings and for vacating, modifying and confirming awards. In addition to this abbreviated statutory arbitration mechanism, common law arbitration is recognized in the District of Columbia. *District of Columbia v. Bailey*, 171 U.S. 161, 18 S. Ct. 868, 43 L. Ed. 118 (1898); *Ruberva Products Co. v. Watson's Quality Turkey Products, Inc.*, 242 A.2d 609 (D.C. App. 1968).

FLORIDA

I. STATUTORY FOUNDATION

Florida has enacted an arbitration statute. *Fla. Stat. Ann.* Sections 682.01 to 682.22 (Supp. 1972) (hereinafter Code).

II. RELATIONSHIP OF STATUTE TO UAA

The Florida arbitration code is modeled after the UAA and is substantially identical to it.

The Code differs from the UAA in two respects. It adds in Section 682.18(2) an explicit procedure for the enforcement of extraterritorial judgments based on arbitration awards, while deleting UAA Section 21 on the uniformity of interpretation of the Code.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, common law arbitration is recognized in Florida, and parties may elect whether to submit their controversy to common law or statutory arbitration. *Arnold's Restaurant, Inc. v. Larson*, 149 So. 2d 664 (Fla. 1966).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 682.08 empowers arbitrators to issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 682.08 empowers arbitrators to administer oaths but does not require that oaths be administered before taking evidence.

c) The Code does not indicate whether strict evidentiary rules are to be observed in the conduct of arbitration proceedings. However, Section 682.06(2) entitles parties to be heard, to present evidence material to the controversy, and to cross-examine witnesses appearing at the hearing.

d) Although Section 682.09(1) requires the award to be in writing and signed by the arbitrators joining in the award, the Code is silent as to whether a transcript of the proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Code does not prohibit an agreement between the parties to have a reporter at the arbitration proceedings. Although the case law gives no indication as to whether the parties may agree to bring a reporter to the arbitration proceeding, it would appear that since the agreement to arbitrate is a contract, the parties could condition their agreement on the presence of a reporter at the proceeding.

f) Except where the grounds for opposing an arbitration award exist under Section 682.13 or where the court declines to confirm an award on grounds other than those stated in Section 682.13(1)(e) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

g) Grounds for judicial review of arbitration awards are substantially identical to the UAA. More specifically, Section 682.13 (Vacating an award) and Section 682.14

(Modification or correction of award) set forth grounds for judicial review of arbitration awards.

h) The Code does not provide for trial de novo of the subject matter of arbitration awards. Section 682.12 provides that upon application of a party to the arbitration, the court shall confirm an award, unless grounds are urged for vacating or modifying the award raised within the statutory time limits.

i) The Code, which is substantially identical to the UAA, contains no peculiar provisions not previously mentioned. *See* Question II, *supra.*

j) No provision of the Code precludes its application to the settlement of personal injury claims.

k) While no provision of the Code precludes its application to the settlement of personal injury claims, no reported appellate court case indicates that it has been used in this manner.

l) Section 682.02 provides that parties may agree in writing to submit to arbitrating existing controversies between them at the time of the agreement and that they may also include in a contract a provision for the settlement by arbitration of any controversy thereafter arising between them relating to their contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there is no reported appellate case law where the Code has been used to resolve personal injury claims, it would appear that the Code, which provides that "any controversy" presently existing or which may arise out of a contract may be settled by arbitration, would encompass the settlement of medical malpractice claims.

GEORGIA

I. STATUTORY FOUNDATION

Georgia has two distinct arbitration statutes: 1) *Ga. Code Ann.* Tit. 7, Sections 7-101 to -111 (1936) (Common Law Arbitration and Award); 2) *Ga. Code Ann.* Tit. 7, Sections 7-201 to -224 (1936) (Statutory Arbitration and Award) (Hereinafter cited as Act).

Although common law arbitration could be used in the malpractice context, it is not recommended and will not be further discussed for the following reasons:

1. Arbitrators only have power conferred by parties and in respect to parties. The arbitration does not have subpoena power.
2. Common law arbitration does not have the procedural safeguards of statutory arbitration.
3. A statutory arbitration award becomes in effect a court judgment whereas a common law arbitration award is only ground for subsequent court action.

The following analysis is based on the Act alone.

II. RELATIONSHIP OF STATUTE TO UAA

Georgia's Act, Sections 7-201 to-224, is not based upon nor related to the UAA. Several dissimilarities not indicated in the analysis of "Procedural Attributes of the Statute" (Question IV) are noteworthy:

> (1) Unlike UAA Section 3, which provides for Court appointment of arbitrators in the absence or ineffectiveness of a method of appointment or where an appointed arbitrator fails or is unable to perform, the Act does not authorize the Georgia courts to appoint arbitrators. Rather, the number and manner of selection of arbitrators are to be specified as follows:
>
> (a) 7-202 (5032) Number of Arbitrators. Every arbitrator under this Chapter shall be composed of three arbitrators, one of whom shall be chosen by each of the parties and one by the arbitrators chosen by the parties.
>
> (b) 7-203 (5033) How arbitrators chosen. When the submission is delivered to the arbitrators chosen by the parties, or either, such arbitrators shall then choose another arbitrator, whose name shall be inserted in the submission.

III. COMMON LAW ARBITRATION

Under the Georgia Code, two modes are provided for the submission of matters in dispute to arbitration. One mode is codified from the common law; the second is a legislative formulation drafted to instill greater confidence in the use of arbitration as a means of resolving disputes.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Act, Section 7-211, clothes the arbitrators with all the powers of the superior courts to compel attendance of witnesses and also to compel them to testify.

Act, Section 7-212 clothes arbitrators with all the powers of the superior courts, to compel parties to produce books and other papers.

b) Testimony is under oath. Only persons who have arrived at sufficient age to understand the obligations of an oath, and are not idiots or lunatics, are competent witnesses. Act, Section 7-213.

Section 7-214 requires the examination of witnesses and the admission of testimony in accordance with the rules of the superior courts.

Section 7-215 empowers arbitrators to administer oaths to witnesses.

c) Strict evidentiary rules are and must be observed. Section 7-214 requires the examination of witnesses and the admission of testimony in accordance with the rules of the superior courts.

d) An analysis of the Act and a review of the case law construing the Act does not indicate any requirement that a transcript of the proceedings be kept. Nor does the case law indicate that a transcript is ordinarily kept.

As the Act does not mandate that there be a transcript of the arbitration proceedings, it is unlikely that the Georgia courts would judicially impose such a requirement unless it could discern or attribute a legislative intent from the Act requiring that a transcript of the arbitration proceedings be kept. This analysis could discern no such legislative intent suggesting that a transcript of the proceedings be kept.

e) Parties to arbitration could agree that a record of their arbitration proceedings be kept. Section 7-201 entitles arbitration awards to be made the judgment of the court where submissions to arbitration are in writing, contain a clear and accurate statement of the matters in controversy and "Any other matter that may be pertinent to said submission." Although this research disclosed no case indicating that a written agreement to keep a record of the arbitration proceedings is a "matter . . . pertinent to said submission", it would seem that the "any other matter" could be construed to authorize and give binding effect to a written agreement to keep a record of the arbitration proceedings.

f) An award made pursuant to the procedural requirements of the Act is final and binding on the parties. Section 7-217 states that the arbitration award "shall be entered on the minutes of said court, and shall have all the force and effect of a judgment or decree of said court, . . . , and shall be final and conclusive between the parties as to all matters submitted to the arbitrators . . . ."

g) Section 7-219 provides that arbitration awards may be reviewed if a party on oath alleges that the award was "the result of accident, or mistake, or the fraud of some one or all of the arbitrators or parties, or is otherwise illegal."

h) There is no trial de novo. Rather, where on oath an award is alleged to be the result of accident, mistake, fraud or other illegality, the "Court shall cause an issue to be made up, which issue shall be tried by a jury under the same rules and regulations as are prescribed for the trial of appeals, ..." Act, Section 7-219; See also Section 7-220.

i) Several other peculiarities of the Act are noteworthy:

1. The examination of witnesses and the admission of testimony is governed by the rules of the superior courts. Section 7-214

2. The award becomes in effect a court judgment. Section 7-217.

3. Challenges to the award are tried by jury. Section 7-219, 220.

j) No provision of the Act makes arbitration inapplicable to personal injury claims.

k) This research has disclosed no reported appellate court case where arbitration has been used to settle a personal injury claim. However, *Ga. Code Ann.* Section 105-1804 (1968) states that "Arbitrament and award is a good defense to an action for a tort . . . ." This language implicitly suggests that arbitration may be used to settle personal injury claims.

l) Common Law Arbitration and Award, Section 7-101 authorizes the submission of existing disputes to arbitration.

The Act, Section 7-201, permits arbitration of future disputes where parties have agreed, in writing, to have specific matters that may be controverted submitted to arbitration.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Georgia's Act is particularly appropriate for Medical Malpractice arbitration. It offers much greater procedural protection than does the UAA. Section 105-1804, cited (k) *supra*, implicitly indicates that the arbitration statute is intended to be used for the resolution of tort claims.

HAWAII

I. STATUTORY FOUNDATION

Hawaii has enacted an arbitration statute entitled *Arbitration and Awards, Hawaii Rev. Stat.* Sections 658-1 to 658-15 (1968) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

Hawaii's arbitration Act is not the same as the UAA but the language of several provisions is substantially identical to that of the UAA.

Dissimilarities between the UAA and the Act are indicated in the analysis of "Procedural Attributes of the Statute." (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Hawaii courts have continued to recognize the validity of and give effect to common law arbitration awards. *Bruner v. C. Brewer & Co.*, 20 Haw. 627 (1911).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 658-7 clothes the arbitrators with the power to subpoena witnesses and documents. Section 658-7 states, in pertinent part:

> The arbitrators . . . may summon in writing any person to attend before them . . . as a witness and in a proper case to bring with him or them a book or paper.

Violators may be punished for refusing or neglecting an arbitrator's summons in the same manner provided for those in contempt of a circuit court summons.

b) The Act is silent as to whether testimony in the arbitration proceeding must be given under oath, and apparently the parties may establish their own procedures in that regard. However, Section 624-12, dealing with depositions, allows parties to arbitration to apply to the courts for depositions, which are taken under oath pursuant to Section 624-16.

c) The Act is silent as to evidentiary rules. The case law suggests that so long as arbitrators conform to the requirements of the Act and hearings are fairly conducted, arbitrators do not appear to be bound by strict evidentiary rules.

d) There is no mention of transcript in the Act, but any motion for a court order confirming, modifying, or correcting an award must be accompanied by the written arbitration award.

e) The Act neither prohibits nor authorizes the parties to bring reporters to their arbitration proceedings. Moreover, just as the Act is silent as to the permissibility of reporters at arbitration proceedings so is the case law construing the Act.

f) Although the Act does not specifically state that an arbitration award is final and binding on the partics, the courts may vacate, modify or correct the award where any of the circumstances described in Sections 658-9, 658-10 are satisfied.

In *Gregg Kendall & Associates v. Kauhi*, 488 P.2d 136, 139 (1971), the Court held that where an agent's action for a commission was referable to arbitration under the terms of a written agency contract, the lower court was required under Section 658-3 to stay such court proceedings and to compel the agent to arbitrate even though arbitration was not the exclusive remedy under the contract.

In *Bruner v. Brewer & Co.*, 20 Haw. 627 (1911), the Court, in regard to the scope of the arbitrators' authority, stated that "arbitrators are not confined to a determination of strict legal rights but may decide upon equitable principles . . . . "

g) Grounds for vacating an award (Section 658-9) and for modifying an award (Section 658-10) are essentially the same as under the UAA.

In *Mars Constructors, Inc. v. Tropical Enterprises, Ltd.*, 51 Haw. 332, 460 P.2d 371, 320 (1969), the Supreme Court of Hawaii ruled that the courts could only modify an arbitration award on the grounds provided for in Section 658-10, and could only vacate an arbitration award on the grounds provided in Section 658-9.

h) The Act makes no specific provision for a trial de novo in the courts. Under Section 658-9 the court may, in its discretion, direct a rehearing by the arbitrator if the time within which the agreement required the award to be made has not yet expired. And in *Notley v. Davies*, 5 Haw. 43, 45 (1883), the Supreme Court of Hawaii held that it could not "reconsider evidence upon the questions properly submitted to the arbitrators." Finally, Section 658-5 allows appeals from a court order vacating or affirming an arbitration award only if the parties have not prohibited such an appeal.

k) The Act does not specifically prohibit arbitration of personal injury claims. However, there are no reported appellate court cases where Hawaii's arbitration scheme has been used to settle personal injury claims.

l) Secion 658-1 makes the Act applicable to the arbitration of future disputes, and Section 658-2 makes the Act applicable to the arbitration of existing disputes if the parties so desire.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there is no reported appellate case law where Hawaii's arbitration has been used to resolve personal injury claims, it would seem that the Act, which provides that "any controversy" presently existing or which may arise out of a contract may be settled by arbitration, would encompass the settlement of medical malpractice disputes.

IDAHO

I. STATUTORY FOUNDATION

Idaho has enacted an arbitration statute. *Idaho Code Ann.* Sections 7-901 to -910 (1947).

II. RELATIONSHIP OF STATUTE TO UAA

The Idaho statute does not contain a number of the procedural provisions which are set out in detail in the UAA. Specifically, there are no provisions for: (1) choosing an arbitrator; (2) guaranteeing the right to the presence of counsel at hearing; (3) changing the award; (4) allocating fees and expenses; (5) specifying a method of delivery of the award; and (6) staying the arbitration proceedings. Furthermore, there is a serious difference between the provisions of the Idaho Act and the UAA with regard to appellate procedure. (See IV (g) below).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, common law arbitration is recognized in Idaho. *See, e.g., Frepons v. Grostein*, 12 Idaho 671, 87 P. 1004 (1906).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) No provision of Idaho's arbitration statute clothes arbitrators with the power to subpoena witnesses or books, records, documents or other evidence.

b) Section 7-904 empowers arbitrators to administer oaths to witnesses, but does not require arbitrators to administer oaths before hearing the testimony of the parties and witnesses. On the other hand, Section 7-905 requires arbitrators to be sworn by an officer authorized to administer oaths before assuming their duties.

c) Both Idaho's arbitration provisions and case law are silent as to whether strict evidentiary rules are observed in arbitration proceedings.

d) Idaho's statute is silent as to whether a transcript of the arbitration proceedings must be kept, and there have been no Idaho court decisions requiring the making of a transcript or invalidating an award for want of a transcript.

e) Idaho's statute and case law are silent as to whether the parties may agree to bring a reporter to the arbitration proceedings. However, it would seem that the parties could condition their agreement to arbitrate on the presence of a reporter at the arbitration proceedings or the making of a transcript of the proceedings.

f) Section 7-903 probides that where a submission is not made an order of the court, it may be revoked at any time before the award is made. On the other hand, where a submission stipulates that it be entered as an order of the district court and an award is made in accordance with the statute's requirements, it is final and binding on the parties and may be enforced by the court in the same manner as a judgment.

g) There is judicial review only on the filing of a motion for modification, correction or vacation of the award. Where the submission stipulates that the award is to be entered as an order of the court it becomes final five days after delivery unless a motion challenging it is filed. After entry of a final judgment, there is no judicial review. Sections 7-907, 7-908.

h) Section 7-909 provides that the rules governing appeals in civil cases shall control appeals from arbitration awards. Therefore, there may be a trial de novo only on review of a proceeding heard on affidavits and documentary evidence alone. *Boise Flying Service v. General Motors Acceptance Corp.*, 55 Idaho 5, 36 P.2d 813 (1934). The only basis for setting aside a final judgment is lack of substantial evidence. *Strickfadden v. Greencreek Highway Dist.*, 42 Idaho 451, 245 P. 934 (1926).

i) The Idaho statute is peculiar in that questions relating to the title of real property are specifically excluded from arbitration by Section 7-901.

j) No provision in Idaho's arbitration statute makes it inapplicable to the settlement of personal injury claims.

k) A review of the case law construing Idaho's arbitration provisions does not reveal any case where arbitration was used to settle a personal injury claim.

l) The statute, Section 7-901, states that parties capable of contracting may submit "any controversy which *might be* the subject of a civil action." (Emphasis added). The question as to whether this refers to agreements to arbitrate future controversies or those already the subject of a civil suit has never been addressed by the Idaho courts. However, Montana courts construing identical language in their arbitration statute have said that this section contemplates only the submission of pre-existing disputes. *Green v. Wolff*, 140 Mont. 413, 372 P.2d 427 (1962).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

As Section 7-901 authorizes the arbitration of "any controversy which might be subject to a civil suit," it would appear that Idaho's arbitration statute could be used to resolve medical malpractice claims. However, it is uncertain as to whether parties could contract to submit disputes which possibly could arise in the future. This uncertainty as to the resolution of future disputes by arbitration might hamper, for example, agreements between patients and doctors to arbitrate malpractice disputes which may arise out of a pending operation.

ILLINOIS

I. STATUTORY FOUNDATION

Illinois has enacted an arbitration statute entitled Uniform Arbitration Act, *Ill. Rev. Stat.*, ch. 10, Sections 101-123 (Smith-Hurd 1966) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The Illinois Uniform Arbitration Act is modeled after the Uniform Arbitration Act. The dissimilarities are indicated as follows:

1. The sections are listed in order of the sections of the Illinois Act, which parallels the UAA's structure.
2. The corresponding UAA section, if any, is indicated in brackets.
3. Although all differences are herein listed, no discussion of the difference will be made unless relevant to the issue of whether the Ill. Stat. is appropriate for settling malpractice suits.

The Illinois Uniform Arbitration Act differs from the UAA in the following respects:

a) Validity of arbitration agreement: Section 101 (Section 1 UAA)

This section omits: "The act also applies to arbitration agreements between employer and employees or between their respective representatives (unless otherwise provided in the agreement)." *See* Section 112(e).

b) Proceedings to compel or stay arbitration: Section 102 (Section 2 UAA)

This section substitutes the word "that" for the words "such as" in the second sentence of subsection (b).

c) Appointment of arbitrators by court: Section 103 (Section 3 UAA)

The UAA provides that the court on application of a party shall appoint arbitrators.

The Illinois counterpart, however, provides that arbitrators can only be appointed by agreement of the parties and if the parties cannot agree on the selection of arbitrators *the entire arbitration agreement shall terminate.* (Differences paraphrased).

d) Majority action by arbitrators: Section 104 (Section 4 UAA)

Identical.

e) Witnesses, subpoenas and depositions; Section 107 (Section 7 UAA)

This section omits in (a): "(Cause to be issued)."

f) Award: Section 108 (Section 8 UAA)

Identical.

g) Change of award by arbitrators: Section 109 (Section 9 UAA)

This section adds after "On application of a party" the phrase "to the arbitrators."

h) Fees and expenses of arbitration: Section 110 (Section 10 UAA)

This section substitutes "attorney's" for "counsel."

i) Confirmation of award: Section 111 (Section 11 UAA)

Identical.

j) Vacating an award: Section 112 (Section 12 UAA)

This section adds a subsection (e): "Nothing in this section or any other section of this Act shall apply to the vacating, modifying, or correcting of any award entered as a result of an arbitration agreement which is a part of or pursuant to a collective bargaining agreement; and the grounds for vacating, modifying or correcting such an award shall be those which existed prior to the enactment of this Act.

Subsection (c) has been changed to read "Section 3" rather than "the agreement, or in the absence thereof, by the court in accordance with Section 3."

k) Modification or correction of award: Section 113 (Section 13 UAA)

Identical.

l) Judgment or decree on award: Section 114 (Section 14 UAA)

This section adds: "As to the court seems just."

Illinois did not adopt and has no counterpart to Section 15 UAA (Judgment Roll, Docketing).

m) Applications to court: Section 115 (Section 16 UAA)

This section adds "in civil cases" at end of first sentence and substitutes "civil cases" for "an action" in the second sentence.

n) Court jurisdiction: Section 116 (Section 17 UAA)

Identical.

o) Venue: Section 117 (Section 18 UAA)

This section inserts the bracketed work in UAA: "county."

p) Appeals: Section 118 (Section 19 UAA)

This section omits subsection (a) and modifies subsection (b) to read: "Appeals may be taken in the same manner, upon the same terms, and with like effect as in civil cases."

q) Act not retroactive: Section 119 (Section 20 UAA)

This section changes "to the taking effect of this act" to read "to the effective date of this Act."

r) Uniformity of interpretation: Section 120 (Section 21 UAA)

Identical.

s) Constitutionality: Section 121 (Section 22 UAA)

Identical; Title of section changed from "Constitutionality" to "Severability."

t) Short title: Section 122 (Section 23 UAA)

identical.

u) Repeal: Section 122 (Section 24 UAA)

This section lists specifically the legislation which this Act repeals. Illinois has no counterpart to Section 24 UAA. (*But See* Section 119, *supra*).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Illinois courts have continued to recognize the validity of common law arbitration. *White Eagle Laundry Co. v. Slarvek*, 296 Ill. 240, 129 N.E. 75 (1920); and see Note, *A Uniform Arbitration Act for Illinois*, 1955 U. Ill. L.F. 297.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 107(a) clothes arbitrators with the power to issue subpoenas for the attendance of witnesses and for the production of books, records and other documents and other evidence.

b) Section 107(a) empowers arbitrators to administer oaths. However, the power is discretionary and arbitrators are not required to administer oaths before taking testimony.

c) The Act is silent as to whether arbitration proceedings must be conducted in accordance with strict evidentiary rules.

Several factors, however, suggest that Illinois courts would not require adherence to strict evidentiary rules in the conduct of arbitration proceedings. First, Illinois courts construed predecessor arbitration statutes as not to require adherence to strict evidentiary rules. *See Lumbard v. Holdiman*, 115 Ill. App. 458 (1904). Secondly, the "historical and practice notes" to Section 107 of the Illinois Act state:

> The traditional practice in arbitration proceedings is that the rules of evidence are not to apply unless the agreement specifies otherwise. See 1 Wigmore, Evidence, Section 4 (3d ed. 1940). It is contemplated that this practice will be followed under the present act.

There are no cases on point under the present Act. One court has interpreted the present Act to require:

> [T]he right to present material evidence, to cross examine witnesses, to have the aid of counsel, and to *all procedural safeguards of an orderly hearing*, including notice. [Emphasis supplied].

School District No. 46, Kane, Cook and DuPage Counties v. Del Bianco, 68 Ill. App. 2d 145, 157, 215 N.E.2d 25, 31 (1966). The language "all procedural safeguards of an orderly hearing" is broad enough to include strict evidentiary rules; *but*, it was not clear that requiring the proceeding to be conducted pursuant to strict evidentiary rules was the court's intention.

d) The Act does not require that a transcript of the arbitration proceeding be kept. However, under Section 101, the parties could make the keeping of a transcript a condition of their agreement to arbitrate. *Cf. Clark v. Courter*, 28 Ill. 590, 117 N.E. 720 (1917), where the Court indicated that the parties could have provided in their arbitration agreement for notes to be taken during the arbitration.

f) Under the Act, an award

> [I]f rendered in compliance with all legal requirements, is a complete, final, and binding determination of a controversy which was properly before the arbitrator.

Ramonas v. Kerelis, 102 Ill. App. 2d 262, 271, 243 N.E.2d 711, 716 (1968).

g) See Section 112(a) for grounds for vacating an award. This provision is identical to UAA Section 12. See Section 113 for grounds for modification or correction of awards. This provision is identical to UAA Section 13.

h) There is no retrial de novo of the subject matter of a validly arbitrated dispute. Section 112(e) limits the grounds for vacating, modifying or correcting arbitration awards to those which existed prior to the enactment of the Act. Those grounds when satisfied did not permit a trial de novo. Rather the reviewing court could order a rehearing before arbitrators. Section 112(e).

i) The Act does not apply to any arbitration covered in part or in whole by a collective bargaining agreement. Section 112(e).

j) No provision of the Act makes arbitration inapplicable to the settlement of personal injury claims. But claims covered by collective bargaining agreement could be drafted to preclude arbitration of personal injury claims.

k) The Act has been used to settle personal injury claims. See e.g., *Liberty Mut. Fire Ins. Co. v. Loring*, 91 Ill. App. 2d 372, 235 N.E.2d 418 (1968) where plaintiff sought to arbitrate injuries received in car accident in accordance with uninsured motorist provision in insurance policy. Milarid, *Arbitration as a Supplement to Judicial Proceedings in Personal Injury Cases*, 1962 U. Ill. L.F. 208; See generally Bondge, *Arbitration of Accident Claim Cases*, 54 Ill. Bar J. 334 (1965).

l) Section 101 provides that a written agreement to submit any existing controversy or any controversy arising subsequent to a written agreement to arbitrate is valid, enforceable and irrevocable save upon such grounds as exist at law or in equity for the revocation of any contract. *White Eagle Laundry Co. v. Slarvek*, 296 Ill. 240, 129 N.E. 753 (1921); See generally *Cocalis v. Nazlides*, 308 Ill. 152, 139 N.E. 95 (1923).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

The Illinois Uniform Arbitration Act has been used to settle personal injury claims and is appropriate for the settlement of medical malpractice claims. Any anticipated due process problems could be eliminated by incorporating any desired procedure into the arbitration contract between the parties.

Note that following are relevant limitations and exceptions to malpractice suits in general: (All *Ill. Rev. Stat.*)

1. Ch. 32, Section 690.42 (1970):

A dental service plan corporation cannot be liable for malpractice.

2. Ch. 83, Section 22.1 (1966):

Maximum statute of limitation for a suit for damages incurred because of foreign objects introduced into the body during an operation is fixed at 10 years from the date of operation.

3. Ch. 91, Section 2a (Supp. 1972):

"Good Samaritan" statute: Only liability for *wilful or wanton* misconduct if emergency care at the scene of an accident or in case of nuclear accident is provided without fee.

4. Ch. 91, Section 69(a) (Supp. 1972):

"Good Samaritan" statute for dental care.

INDIANA

I. STATUTORY FOUNDATION

Indiana has enacted an arbitration statute. *Ind. Code Ann.* Sections 3-227 to 3-248 (Burns Cum. Supp. 1971) (*Ind. Code* 34-4-2-1 to 34-4-2-20 (1971)) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

In 1969, the Indiana Legislature enacted its own Uniform Arbitration Act. Acts 1969, Ch. 340, Section 20. Section 24 of Acts 1969, Ch. 340 repealed those former arbitration provisions contained in *Ind. Code Ann.* Sections 3-201 to 3-226 (Burns Repl. Vol. 1946) which were inconsistent with the Act. See "Compiler's Note" Section 3-248 (34-4-2-21) where the repeal section is compiled. Specifically, Section 24 of Acts 1969, Ch. 340 states: "All acts or parts of acts which are inconsistent with the provisions of this act (Indiana's Uniform Arbitration Act) are hereby repealed . . . . "

The Indiana Uniform Arbitration Act, which became operative August 18, 1969, is modeled after and is substantially identical to the UAA. It differs from the UAA in the following respects:

1) Section 22 (Constitutionality) and Section 24 (Repeal) of the UAA are not codified in Indiana's Act. However, while not codifying these sections, the Indiana Legislature did specify in the legislation adopting the Act under a section entitled "Separability" that "If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable." See Section 22 of Acts 1969, Ch. 340 in Compiler's Notes at Act Section 3-248 (34-4-2-21). Similarly, the Indiana Legislature specified in Section 24 of the adopting legislation that inconsistent acts or parts of acts were repealed by the enactment of its Uniform Arbitration Act.

2) The Indiana Legislature added a provision to its Uniform Arbitration Act which is not found in the UAA. Section 3-226 (34-4-2-2) of the Act specifies the method by which arbitration shall be initiated. It states:

> Arbitration shall be initiated by a written notice by either party, mailed by registered or certified mail, or delivered to the other party, briefly stating a claim, the grounds for the claim and the amount or amounts. Issues shall be joined by written notice of admissions or denials and any counterclaims or set-offs so mailed or delivered. The statutes of limitations shall cease to run from the time of any notice of claim or counterclaim.

3) Section 3-230 (34-4-2-3) of the Act adds two provisions to "Proceedings to compel or stay arbitration" which are not included in Section 2 of its UAA counterpart. First, Section 3-230(f) provides that if there are other issues between the parties which are not the subject of arbitration and which are the subject of a pending action or special proceeding and that a determination of these issues is likely to make the arbitration unnecessary, the court may delay its order to arbitrate until these other issues are decided. Secondly, Section 3-230(g) provides that the court may stay an arbitration proceeding on a showing that the method of appointment of the arbitrator

is likely to or has resulted in a majority of arbitrators who are partial or biased in a respect material to the controversy.

4) The Indiana Act affords parties longer notice of scheduled hearings than does the UAA. Whereas Section 3-233(a) (34-4-2-6) requires arbitrators to notify parties of the time and place of the hearing at least 30 days before the hearing is to be held, Section 5(a) only requires that the arbitrators give parties 5 days' notice of the date the hearing is to be held.

5) Like UAA Section 5(b), Section 3-233(b) (34-4-2-6) affords parties the right to be heard, to present any evidence material to the controversy. Furthermore, Section 3-233(b), unlike UAA Section 5(b), specifies that the evidence may be presented "regardless of its admissibility under judicial rules of evidence." On the other hand, where UAA Section 5(b) specifically provides that parties are entitled to "cross-examine witnesses appearing at the hearing," Section 3-233(b) of the Act makes no similar express guarantee.

6) Unlike UAA Section 7(a), Section 3-235(a) (34-4-2-8) of the Act limits arbitrators' power to subpoena financial records in disputes between labor and management.

7) While UAA Section 8(a) implicitly requires arbitrators to include in their awards a determination of all questions material to the controversy, Section 3-236 (34-4-2-9), in addition to requiring that awards be in writing and signed by the concurring arbitrators, specifically states that the award "shall include a determination of all the questions submitted to the arbitrations the decision of which is necessary in order to determine the controversy."

8) Unlike UAA Section 11, Section 3-239(34-4-2-12) of the Act makes clear that an award can only be confirmed by the court where 90 days have expired from the date of the mailing of a copy of the award to all the parties.

9) Section 3-244 (34-4-2-17) of the Act specifies that the superior court is the court of competent jurisdiction.

10) UAA Section 15, Judgment Roll, Docketing, has been omitted from Indiana's Act.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Indiana Courts have continued to recognize the validity of common law arbitration. *Heritage v. State ex rel. Crim.*, 43 Ind. App. 595, 88 N.E. 114 (1909).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 3-235(a) (34-4-2-8) empowers arbitrators to issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence. However, the arbitrators' subpoena power is limited where the arbitration is between labor and management. In this case, arbitrators cannot subpoena financial books or records of either labor or management.

b) Section 3-235(a) empowers arbitrators to administer oaths but does not require that arbitrators administer oaths before taking testimony.

c) It appears that the Act does not require that arbitration proceedings be conducted in accordance with strict evidentiary rules. Support for this conclusion can be garnered from Section 3-233(b) which states: "The parties are entitled to be heard, to present any and all evidence material to the controversy *regardless of its admissibility under judicial rules of evidence.*" [Emphasis added].

d) Although Section 3-236(a) (34-4-2-9) requires that "The award shall be in writing and signed by arbitrators joining in the award," the Act is silent as to whether a transcript of the arbitration proceeding must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act and case law are silent as to whether the parties may bring a reporter to the arbitration proceedings. However, it would appear that the parties could condition their agreement to submit a controversy to arbitration on the presence of a reporter at the proceedings or even that a transcript be kept by the arbitrators.

f) Except where the grounds for opposing an arbitration award exist under Section 3-240 (34-4-2-13) and 3-241 (34-4-2-14) or where the court declines to confirm an award on grounds other than those stated in Section 3-240(a), (5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

g) Grounds for judicial review are substantially identical to those of the UAA. More specifically, Section 3-240 (34-4-2-13) (Vacating an award) and Section 3-241 (34-4-214) (Modifications or correction of award) set forth grounds for judicial review of arbitration awards.

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Rather, where an award is rendered in compliance with all the Act's requirements, it is a final and binding determination of the issue submitted and precludes a de novo determination of that issue by a court or by a subsequent arbitration.

i) With the exception of those dissimilarities between the Act and the UAA identified in Question II, *supra*, there are no other peculiarities in the Act.

j) No provision of the Act precludes its application to the settlement of personal injury claims.

k) Although the Act does not preclude its application to the settlement of personal injury claims, there have been no reported appellate court cases where the Act has been used to resolve a personal injury claim.

l) Section 3-228 (34-4-2-1) expressly recognizes the validity of agreements to settle existing and future disputes by arbitration. In pertinent part, it states: "A written agreement to submit to arbitration is valid, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract."

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although no reported appellate court cases show the Act to have been used to resolve a personal injury claim, it should be recognized that the Act is a recent enactment and that only a small pool of cases have construed its provisions.

On the other hand, the Act is modeled after the UAA and the Indiana Legislature has enacted a provision stating that the Act shall be construed to make uniform the law of those states which enact similar statutes. Section 3-248 (34-4-2-21). Given the fact that in other states which enacted the UAA personal injury claims and medical malpractice claims have been resolved, it would appear that the Indiana courts would recognize the validity of and give effect to awards resolving medical malpractice claims under the provisions of the Act.

IOWA

I. STATUTORY FOUNDATION

Iowa has enacted an arbitration statute. *Iowa Stat. Ann.* Sections 679.1–679.19 (1966) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

While Iowa's Act was enacted prior to the fashioning of the UAA, its arbitration mechanism is nevertheless basically the same as the UAA. Dissimilarities between the UAA and the Act are indicated in the analysis of "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to Iowa's statutory arbitration scheme, common law arbitration is recognized. The Act has been construed no to be the exclusive arbitration mechanism or a bar to common law arbitration. *First Nat. Bank in Cedar Falls v. Clay*, 321 Iowa 703, 2 N.W.2d 85 (1942).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) While the Act does not empower arbitrators to issue subpoenas, Section 214 of Iowa's Rules of Civil Procedure clothes arbitrators with the power to compel the attendance of witnesses and the production of books, documents and other evidence.

b) Section 679.5 (Cum. Supp. 1972) empowers arbitrators to administer oaths to witnesses but does not require that oaths be administered before taking evidence.

c) Section 679.5 (Cum. Supp. 1972) provides that strict evidentiary rules need not be observed in taking evidence. In pertinent part, it states that " . . . the board may accept demand and call for such evidence as in equity and good conscience the board may deem material and proper, whether strictly legal evidence or not." Given this provision allowing evidence to be received by the arbitrators which is not strictly legal evidence, it is likely that the arbitration proceedings are generally less formal than judicial proceedings. Of course, it must be recognized that Section 679.5 (Cum. Supp. 1972) provides that "All the rules prescribed by law in cases of referees are applicable to arbitrators, except as herein otherwise expressed, ... " Moreover, the parties could provide pursuant to Section 679.5 that strict evidentiary rules be adhered to in the conduct of their arbitration proceedings.

d) Although the Act is silent as to whether a transcript of the arbitration proceedings must be kept, Iowa Rules of Civil Procedure, Section 214 states that an arbitrator " . . . shall, on request, make a record of evidence offered and excluded."

e) The Act is silent as to whether the parties may agree to bring a reporter to the arbitration proceedings. However, it would appear that the parties as a condition to their agreement to arbitrate could provide that a reporter be present at the proceedings.

f) Section 679.12 states that "the award may be rejected by the court for any legal and sufficient reasons, or it may be recommitted for a rehearing to the same arbitrators, or any others agreed upon by the parties, or appointed by the court if they cannot agree."

While the sweep of Section 679.12 would appear to be so broad as to preclude an arbitration award from becoming final and binding on the parties, it has been narrowly construed. The Iowa courts have held that an arbitration award is not to be impeached for a mistake of law. *Shulte & Wagner v. Hennessy*, 40 Iowa 352 (1895). Nor is the award to be impeached where, on the evidence, a court or jury might have reached a different conclusion. *Ames Canning Co. v. Dexter Seed Co.*, 195 Iowa 1285, 190 N.W. 167 (1922). In sum, as construed by the Iowa courts an award made pursuant to the Act is final and binding on the parties except where fraud or material mistake is shown. *Struthers v. Clark,* 40 Iowa 508 (1875).

g) Grounds for setting aside an arbitration award are embodied in the language of Section 679.12 which states that "The award may be rejected by the court for any legal and sufficient reasons . . . . "

Although the Act does not catalogue grounds for judicial review as does the UAA (See sections 12 and 13), the grounds found sufficient for reviewing an arbitration award are similar to the UAA.

In *Vincent v. German Insurance Co.*, 120 Iowa 272, 94 N.W. 458 (1903), the Supreme Court of Iowa indicated that while mistakes of judgment were not grounds for setting aside an award, evidence of "partisan bias" was sufficient. In making this point, the Court said: "Mistake of judgment on the part of arbitrators is not ground for setting aside an award unless such mistake be so great as to indicate partisan bias." *Vincent v. German Insurance Co., supra*, 120 Iowa at 277, 94 N.W. at 460.

Additionally, it should be noted that at common law the Iowa courts would not review an award unless there was a showing of fraud, corruption, partiality or misconduct on the part of the arbitrators, or some fraud on the part of the party relying upon the award, or a material mistake which entered into it. *Thornton v. McCormick*, 75 Iowa 285, 288, 39 N.W. 502, 503 (1888). In sum, statutory and common law construction of the grounds for judicial review and Section 679.18 which provides that "Awards by arbitrators who have been chosen without complying with the provisions of this chapter shall nevertheless be valid and binding upon the parties thereto, as other contracts, and may be impeached only for fraud or mistake, but such award can only be enforced by action," suggest that grounds for judicial review are similar to those of Section 12 (Vacating an award) and Section 13 (Modification or correction of an award) of the UAA.

h) While Section 679.12 provides that an award may be rejected by the court for any legal and sufficient reasons, such as fraud, partiality and an award beyond the submission, the case law indicates that the courts will either correct the arbitrators' errors and remand the controversy to the arbitrators to be decided in accordance with the court's opinion or order a rehearing of the arbitration before newly chosen arbitrators. Where no grounds for setting aside or correcting an award are shown then when the award has been adopted by the court pursuant to Section 679.13 the award is final and binding on the parties.

The Iowa courts have consistently emphasized the fact that arbitrations are favored by law and their reluctance to set aside an award and decide the controversy de novo.

Vincent v. German Insurance Co., 120 Iowa 272, 277, 94 N.W. 458, 460 (1903), stands for the proposition that arbitration is favored in law. In *Vincent*, the Supreme Court of Iowa asserted:

> " . . . In order to justify a court in setting aside an award, the misconduct or other ground of impeachment must be made out by clear and satisfactory evidence. . . . Every reasonable presumption will be indulged in favor of the award."

The court continued in *Vincent* and stated that as a matter of public policy "Arbitrations are favored in law, and an award, when made, will be upheld, unless the evidence clearly shows such misconduct or mistake on the part of the arbitrators as to justify a court in setting it aside." *Vincent v. German Insurance Co., supra,* 120 Iowa at 279, 94 N.W. at 460.

In sum, the statements of the Iowa courts favoring arbitration and its recognition of the legislative policy of avoiding litigation implicit in the enactment of the arbitration statute indicate that a trial de novo is not generally available.

i) There are several noteworthy peculiarities in the Act. Recently, the Iowa legislature added a provision, Section 679.19 (Disputes between governmental agencies) which prohibits litigation between administrative departments, commissions or boards of the state government and requires all disputes between these governmental agencies to be submitted to a board of arbitration whose award "shall be final."

Secondly, the Act is peculiar in that the grounds for review and setting aside an award are not specified but have been broadly cast in the language of Section 679.12. This legislative drafting suggests that the Iowa legislature, unlike most legislatures which list grounds for review and setting aside an award, preferred to have the courts explicate what grounds would be sufficient for reviewing and setting aside an award.

j) No provision of the Act prohibits its application to the settlement of personal injury claims. On the contrary, Section 679.1 provides that "All controversies which might be the subject of civil action may be submitted to the decision of one or more arbitrators . . . . " This language would appear to encompass the resolution of personal injury claims by arbitration.

k) The Act has been used to resolve personal injury claims.

In *McKinney v. Western Stage Co.*, 4 Iowa 420, 4 Clarke 420 (1857), plaintiff-husband submitted to arbitration his claim for damages resulting from injuries to his wife caused by defendant Coach Company's negligence. The arbibrators awarded plaintiff damages for the loss of the "society of his wife" and his "being put to the expense on account of injury received by her." The report of the award was filed with the Court as provided by the agreement and the Act, at which time defendant filed its petition for a writ of error which the District Court dismissed. In upholding that dismissal the Supreme Court of Iowa said that the writ was properly dismissed and that the award to husband for his personal loss was a proper subject for submission.

l) While Section 679.1 provides that "All controversies which might be the subject of civil action may be submitted to arbitration," the language does not specifically include agreements to submit disputes which could arise in the future. Moreover, Section 679.3 provides that "The submission may be of some particular matters or demands . . . . " This statutory language, which on its face appears to comtemplate agreements to submit existing disputes, has been construed to encompass only agreements to submit existing disputes. In short, agreements to submit future disputes are not binding on the parties.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given the favored position of arbitration under Iowa law and its prior use to settle existing personal injury claims, it would appear that the Act would be well-suited for the resolution of medical malpractice claims.

KANSAS

I. STATUTORY FOUNDATION

Kansas has enacted an arbitration statute. *Kan. Stat. Ann.* Sections 5-201 to 5-213 (1963).

II. RELATIONSHIP OF STATUTE TO UAA

The Kansas arbitration statute, which was enacted in 1876 and which has remained substantially unchanged since then, is not similar to the UAA. Dissimilarities between the statutes are indicated in the analysis of the "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Kansas Courts have continued to recognize the validity of common law arbitration. *Wagoner v. City of Hutchinson*, 169 Kan. 44, 216 P.2d 808 (1950).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) No provision of the Kansas arbitration statute clothes arbitrators with the power to subpoena witnesses. In contrast with the UAA which explicitly authorizes arbitrators to subpoena witnesses, documents and other evidence, the Kansas statute does not equip arbitrators with any "judicial" power regarding the conduct of arbitration proceedings.

Although arbitrators do not have the subpoena power, Section 5-204 provides "That the parties shall have the benefit of legal process to compel the attendance of witnesses; which process shall be issued by the clerk of the district court, or by any justice of the peace for any county in which said arbitration shall be held . . . . "

While the statute is silent as to whether parties shall have the benefit of legal process to compel witnesses to produce documents, Section 5-205 provides that any person disobeying process after being duly served, is guilty of contempt of court from which the process issued and is subject to the same penalties the court is authorized to inflict upon persons disobeying writs of subpoena in other cases.

b) Section 5-206 requires witnesses to testify under oath. In pertinent part, Section 5-206 states "that the . . . arbitrators and all witnesses . . . to such arbitration, examined by the . . . arbitrators, shall be under oath or affirmation to be administered . . . by any judge or justice of the peace of the proper county."

c) The Kansas arbitration statute does not provide that strict evidentiary rules be observed.

The Kansas case law indicates that proceedings can be informally conducted. *Coleman v. Local No. 570*, 181 Kan. 969, 317 P.2d 831 (1957). In *Coleman*, management challenged the arbitration board's award in their labor dispute with Local No. 570 on the ground that the award was inconsistent with the arbitration agreement. In approving the board's award, the court noted that the arbitration proceeding was in fact and could in law be informally conducted.

Given the Court's assertion in *Coleman* that arbitration proceedings may be informally conducted, it would appear that strict evidentiary rules do not have to be followed. However, it must be noted that the Kansas courts have not been specifically confronted with the question of whether strict evidentiary rules must be observed in conducting arbitration proceedings.

d) While Section 5-207 requires arbitrators to draw up in writing and sign their award and to deliver a copy of the award to each of the parties in interest, the Kansas statute is silent as to whether a transcript of the arbitration proceeding must be kept.

Although the statute is silent as to whether a transcript must be kept, in *Gillioz v. City of Emporia*, 149 Kan. 539, 542, 88 P.2d 1014 (1939), the Supreme Court of Kansas held that an arbitration award is valid where a transcript of the proceeding is not kept. The Court held that a transcript did not have to be kept notwithstanding the fact that one party had requested the arbitrators to keep a transcript. Rather, the Court held that it was within the discretion of the arbitrators under the agreement whether to keep a transcript.

f) Section 5-209 provides that if no legal exception be made to an arbitration award, it shall be entered as a verdict of a jury between the parties by the court. Thus, in effect, the award is final and binding upon the parties.

In *Hopper v. Fromm*, 92 Kan. 142, 143, 141 P.175, 176 (1914), the Court held that to have a binding statutory arbitration award three elements are required: ". . . an agreement to arbitrate, followed by an award in writing signed by the arbitrator or a majority of them."

Section 5-210 provides that a party disobeying the award "shall be liable to be punished as for a contempt of court. . . . " In addition to this statutory remedy for a party's noncompliance with the arbitration award, Section 5-202 provides that parties who have agreed to submit a dispute to arbitration may enter into arbitration bonds conditioned upon the faithful performance of the award.

g) Grounds for judicial review are stated in Section 5-211. It provides that an award may be set aside where "any legal defects appear in the award" or where it appears that the award was "obtained by fraud, corruption, or other undue means," or that the arbitrator "misbehaved."

In *Gillioz v. City of Emporia*, 149 Kan. 539, 88 P.2d 1014 (1939), the Court invalidated a portion of the arbitrators' award reached without showing the evidence supporting their decision in their written award as required by Section 5-207. In reaching its decision that a portion of the award was invalid because of the arbitrators' "misbehavior," the court pointed out that ". . . [T]he arbitration award having been made under the statute can only be set aside for reasons stated in the statute" which the Court said were: "(1) legal defects; (2) fraud, corruption or other undue means; and (3) misbehavior of the arbitrators." *Gillioz v. City of Emporia, supra*, 149 Kan. at 541, 542, 88 P.2d at 1016.

h) While the Kansas statute states grounds for judicial review, it does not authorize the courts to hear de novo the controversy where those grounds are satisfied.

In *Gillioz v. City of Emporia*, 149 Kan. 539, 542, 88 P.2d 1014, 1017 (1939), the Kansas Supreme Court explicitly approved the lower court's ruling that it is not the courts' function to hear arbitration disputes de novo. The Court stated that "it was not the function of the Court, under the arbitration statute, to hear de novo the matters heard by the board . . . . "

i) The Kansas arbitration statute, as it has been construed by the courts, is peculiar in that an agreement to submit a controversy to arbitration is revocable before an award has been made.

In *Thompson v. Phillips Pipe Co.*, 200 Kan. 669, 438

P.2d 146 (1968), the Court refused to specifically enforce an agreement between the pipe company and the plaintiff to arbitrate any damage to plaintiff's land caused by the company's pipe line. In refusing to specifically enforce the agreement to arbitrate, the Court stated:

> [T]his court has followed the common law rule that an agreement to submit a matter to arbitration is revocable at will by either party while it is executory, that is, at any time before an award has been made, and that such agreements are invalid or at least unenforceable either at law or equity.

Thompson v. Phillips Pipe Co., *supra*, 200 Kan. at 674, 438 P.2d at 150.

However, it should be noted *Thompson* does not stand for the proposition that a party may unilaterally withdraw from arbitration proceedings at any time. In *Guild v. The Atchison, Topeka & Santa Fe Ry.*, 57 Kan. 70, 45 P.82 (1896), which involved a dispute over damage allegedly caused by the railroad's track to plaintiff's land, the plaintiff agreed to forego all claims against the railroad in favor of the railroad paying damages to be determined by arbitration.

Pursuant to the parties' agreement to submit the question of damages to arbitration, a decision was reached by two of the three arbitrators but an award was not made because the railroad's request to submit arguments and introduce evidence was granted. During the day granted to the railroad to gather evidence it withdrew from the arbitration. The Kansas Supreme Court, in compelling the railroad to submit to arbitration, stated that the company could "not retain an advantage gained by the contract and revoke the authority of the appraisers." *Guild v. Atchison, Topeka & Santa Fe Ry.*, *supra*, 57 Kan. at 80, 45 at P. 85.

The critical differences between *Thompson* and *Guild* which should be recognized are that in *Thompson* the defendant refused to even appoint an arbitrator, thereby impliedly revoking the agreement while in *Guild* not only had the parties appointed arbitrators and two of the arbitrators reached a decision but the plaintiff relinquished his right to bring a judicial action in return for the railroad's promise to arbitrate the extent of damages to plaintiff's land.

j) Kansas' arbitration statute does not prohibit the settlement of personal injury claims by arbitration.

k) While it would seem that personal injury claims could be settled by arbitration under Kansas' arbitration statute, no appellate court case has been decided where the statute has been used to settle personal injury claims.

In *Miller v. Brumbaugh*, 7 Kan. 215, 218-219 (1871), a case involving the submission of a claim for extra labor and material on a building contract, the Supreme Court of Kansas quoted with approval this principal of law from a commentator's treatise on arbitration:

> 'Any controversy relating to personal property may form the subject of a reference. And *in all cases of injury, either to person* or property, where damages would be recoverable by action, the arrangement of the matter may be left to arbitration. . . . ' [Emphasis added].

l) Section 5-201 specifically provides "That all persons who shall have any controversy . . . may submit such controversy . . . to arbitration . . . . " This language suggests that the statute is only applicable to existing controversies and not controversies which might arise in the future. In sum, it appears that agreements to submit future controversies does not constitute a binding contract for which damages would be awarded for a breach.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

The Kansas arbitration statute provides that any existing controversy may be submitted to arbitration. Although personal injury claims using the statute's arbitration mechanism do not appear in the reported decision, the statutory language and court dicta would seem to encompass the settlement of medical malpractice claims. However, in the light of *Thompson v. Phillips Pipe Co.*, 200 Kan. 669, 438 P.2d 146 (1968), where a party was able to revoke his agreement to arbitrate by refusing to appoint an arbitrator, injured parties or defending doctors and hospitals might be reluctant to use Kansas' arbitration mechanism to settle medical malpractice claims.

Unlike the UAA which in Section 3 authorizes the court to appoint arbitrators where the arbitration agreement's method of appointing arbitrators fails or where no method of appointment is stipulated, the Kansas statute's only solution to the problem of inducing a recalcitrant party to submit to arbitration as agreed is a provision for entering into a arbitration bond. Section 5-202. However, the use of the arbitration bond does not seem to be an effective alternative. On the one hand, the patient would not wish to post a bond which would not be a necessary expense if he went to court and which later might prevent him from choosing the courts as an alternative forum for resolving his claim. On the other hand the bond-posting would only add to a doctor's or hospital's malpractice expense.

KENTUCKY

I. STATUTORY FOUNDATION

Kentucky has enacted an arbitration statute. *Ky. Rev. Stat.* Sections 417.010–417.040 (1942).

II. RELATIONSHIP OF STATUTE TO UAA

The Kentucky arbitration statute is far less inclusive than the UAA. Absent are due process provisions (e.g., right to counsel at hearing) as well as the detailed sections regarding vacation, modification and confirmation of the award. However, litigation under the statute has afforded the Kentucky courts an opportunity to fill the interstices so that the statute as construed bears a closer resemblance to the UAA than it does on its face.

III. COMMON LAW ARBITRATION

While the Kentucky legislature provided for a statutory scheme of arbitration, its enactment has not been construed as an abrogation of common law arbitration. *Gannon v. McClannahan*, 204 Ky. 67, 263 S.W. 770 (1924).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 417.013 clothes arbitrators with the power to issue subpoenas for witnesses "to attend their sittings and give evidence touching the questions referred to them."

b) Section 417.016 empowers arbitrators to administer oaths to witnesses but does not require that oaths be administered before taking their evidence. On the other hand, Section 417.012 requires arbitrators to take an oath before assuming their duties.

c) The Kentucky arbitration statute is silent as to whether arbitration proceedings must be conducted in accordance with strict evidentiary rules. The absence of a statutory command requiring strict adherence to evidentiary rules and the absence of case law on this point suggest that the proceedings are informally conducted.

d) The Kentucky arbitration statute is silent as to whether a transcript of the arbitration proceedings must be kept, and there have been no Kentucky court decisions either requiring the making of a transcript or invalidating an award for want of a transcript. On the other hand, Section 417.016 requires the arbitrators to make their award in writing and deliver signed copies of the award to each of the contending parties.

e) Kentucky's statute and case law are silent as to whether the parties may agree to bring a reporter to the arbitration proceedings. However, it would seem that the parties could condition their agreement to arbitrate on the presence of a reporter at the arbitration proceedings or the making of a transcript of the proceedings.

f) Where an arbitration award is entered as a judgment of the court pursuant to Section 417.017, it is final and binding on the parties and carries all the attendant force and effect of a judgment by a court. *General Exchange Ins. Corp. v. Harmon*, 288 Ky. 624, 157 S.W.2d 126 (1941).

g) Grounds for judicial review are limited to challenges asserting "equitable" claims. Essentially, this means that grounds for judicial review are limited to fraud in the procuring of the award. *Phillips v. Phillips*, 81 Ky. 147, 4 R. 941 (1883). Further, if an award is found to encompass questions not submitted to arbitration, those elements of the award relating to questions beyond the competence of the arbitrators will be stricken and the remainder of the award enforced. *Adams v. Ringo*, 79 Ky. 211, 1 R. 251 (1880).

h) There is no trial de novo of the subject matter of a dispute submitted to arbitration. Mistakes, whether of law or fact, which do not prove partiality or corruption cannot be set aside and retried on review. *Adams v. Ringo, supra.*

i) The statute is peculiar in that it explicitly provides that a fiduciary may enter into an agreement to arbitrate. Section 417.014.

j) No provision of Kentucky's statute prohibits agreements to arbitrate personal injury claims.

k) While no provision of Kentucky's statute prohibits agreements to arbitrate personal injury claims, there have been no reported appellate court cases where it has been used to settle a personal injury claim.

l) Although Section 417.010 provides that "Any controversy that might be the subject of an action" may be submitted to arbitration and although Section 417.011 provides that "Any controversy which is or might be the subject of an action may" be submitted to arbitration, no provision authorizes agreements to arbitrate controversies which may arise in the future. Indeed, the Supreme Court of Kentucky has held that agreements to arbitrate disputes which could arise at some future date were invalid. *Gaither v. Dougherty*, 18 Ky. Law Rptr. 709, 38 S.W. 2 (Ky. App. 1896); *Ison v. Wright*, 21 Ky. Law Rptr. 1368, 55 S.W. 202 (Ky. App. 1900).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although case law does not reveal the use of Kentucky's statute to resolve personal injury claims and although the statute, as construed, has been limited to agreements to arbitrate existing disputes, the language in Section 417.010 and 417.001 stating that "Any controversy" which might be the subject of an action may be arbitrated suggests that the statute could be used to resolve existing medical malpractice claims. The statute, however, would be inapplicable to agreements to submit future medical malpractice disputes arising out of a contract to arbitration.

LOUISIANA

I. STATUTORY FOUNDATION

Louisiana has enacted an arbitration law. *La. Stat. Ann.* Sections 9:4201 to 9:4217 (1950) (hereinafter Law).

II. RELATIONSHIP OF STATUTE TO UAA

The ambit of the Louisiana statute, though not as procedurally precise, includes the basic provisions of the UAA. The period for confirmation of the award is longer, and most of the hearing formalities have been derived from litigation under the statute rather than from the Law itself.

III. COMMON LAW ARBITRATION

Louisiana is a civil law jurisdiction. Authority for the legislature to enact rules governing arbitration is contained in the State Constitution. *La. Const.* Art. III, Section 36.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 4206 empowers arbitrators to summon in writing witnesses to attend the arbitration proceedings and in a proper case to bring any book, document, or paper which may be deemed material as evidence in the case.

b) There is no provision for the administration of oaths to witnesses in the statute. It does provide, however, that depositions may be taken and used as evidence from which fact it could be inferred that testimony is under oath. Furthermore, it has been said that where rules of procedure are not prescribed by statute, the proceeding is governed by the ordinary rules of practice and procedure obtained in the,place where the arbitration is held. *Housing Authority of New Orleans v. Henry Ericsson Co.*, 197 La. 732, 2 So. 2d 195 (1941).

c) There is no statutory provision regarding the conduct of arbitration proceedings in accordance with the rules of evidence. However, the Louisiana court has held that the agreement may stipulate that the proceeding be conducted in accordance with evidentiary rules. *Housing Authority of New Orleans v. Henry Ericsson Co., supra.*

d) Louisiana's arbitration law is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that parties need not and do not as a matter of practice keep a formal transcript.

e) The Law is silent as to whether reporters may be brought to the arbitration proceedings. It would appear, however, that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present or even that the arbitrators keep a transcript of the proceedings.

f) Section 4209 provides that any party to the arbitration may file a motion with the court to have the award confirmed and entered as a judgment within one year. Where judgment is entered on the award it has the effect of a final judgment. *Livingston v. Shreveport-Texas League Baseball Corp.*, 128 F. Supp. 191 (W.D. La. 1955), *aff'd per curiam*, 228 F.2d 623 (5th Cir. 1956); *Bergeron v. Gassen*, 185 So.2d 106 (La. App. 1966).

g) Grounds for judicial review of an arbitration award are substantially identical to those of the UAA. Section 4210 (Motion to vacate award; jurisdiction; notice) and Section 4211 (Motion to modify or correct award; grounds) set forth grounds for judicial review of arbitration awards.

h) There is no trial de novo by the courts of the subject matter of the arbitration controversy. Rather, the award is ordinarily conclusive on the merits of all matters properly within the scope and intended by the arbitrators to be finally decided. *Housing Authority of New Orleans v. Ericsson Co., supra.*

i) The Louisiana arbitration law is peculiar in two respects: (1) it is not applicable to labor disputes; and (2) unless otherwise stated in the agreement, a single arbitrator is sufficient to resolve a controversy submitted by the parties.

j) No provision of the Law prohibits the resolution of personal injury claims by arbitration.

k) While it would seem that the Law is applicable to the resolution of personal injury claims, no reported appellate court case has been decided where the Law has been used to settle such claims.

l) Louisiana's arbitration law covers both agreements to arbitrate existing disputes and contracts to arbitrate any future disagreements. Section 4201; *Housing Authority of New Orleans v. Ericsson, Co., supra.*

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

While no reported appellate case indicates that Louisiana's arbitration law has been used to resolve personal injury claims, the Law specifically provides that parties may contract to submit to arbitration any existing controversy or settle by arbitration a dispute arising out of a contract. Since the arbitration law encompasses both existing and future disputes and given the procedural mechanism which the Law provides, and Louisiana's policy to favor arbitration, it would seem that it could be used to resolve medical malpractice claims.

MAINE

I. STATUTORY FOUNDATION

Maine has enacted an arbitration statute. *Me. Rev. Stat. Ann.*, Tit. 14 Sections 5927–5949 (Cum. Supp. 1971) (hereinafter Act.)

II. RELATIONSHIP OF STATUTE TO UAA

Before Maine's enactment of its own version of the Uniform Arbitration Act there were two types of statutory arbitration in Maine, neither of which were similar to the UAA. *Me. Rev. Stat. Ann.* Tit. 4 Section 501; Tit. 14 Sections 1151-1155 (1964). Under these acts, an issue which was the subject of an action in the courts could be submitted to arbitration on agreement of the parties with leave of the court. A separate statute provided that a question which might form the basis of a personal action could be settled through arbitration if the parties so desired. The powers of the referees (arbitrators) under both titles were the same, and the reports of both had to be accepted by the court to become final. The Maine statute was one of the few which made provision for the formalities of the referees' hearing. However, it was silent as to the parties right to representation at the hearing. Statutory appeal procedures were circumscribed, but the scope of appeal was similar to that of the UAA.

In 1967 the Maine Legislature modernized its arbitration provisions by enacting its own "Uniform Arbitration Act", modeled after and substantially identical to the UAA.

The Act differs from the UAA in three major respects:

1) Section 5938 of the Maine Act adds a specific clause which provides that the court shall vacate an award where: "The award was not made within the time fixed therefor by the agreement or, if not so fixed, within such time as the court has ordered, and the party has not waived the objection . . . . " Section 5938(1) (F).

2) The Maine Act adds a section saving a specialized arbitration statute and expressly precluding the Act's

application to a specific subject matter. Section 5948 states that "Nothing in this chapter shall be deemed to repeal or amend Title 26 Chapter 10, entitled 'Fire Fighters Arbitration Law.' This chapter shall not apply to any provision contained in a policy of automobile liability insurance for arbitration of a claim under the uninsured motorist coverage."

3) The Maine Act omits UAA Section 22 entitled "Constitutionality".

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, common law arbitration is recognized in Maine. *Bodge v. Hull*, 59 Me. 225 (1870).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 5933(1) empowers arbitrators to cause to be issued subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 5933(1) empowers arbitrators to administer oaths but does not require that oaths be administered before taking evidence.

c) Section 5931(2) states "The parties are entitled to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing." Beyond these safeguards, the Act is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

d) Although Section 5934(1) requires that "The award shall be in writing and signed by the arbitrators concurring in the award . . . ", the Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act and case law are silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings or even on the keeping of a transcript.

f) Although there have been no reported appellate court cases holding that an award made in accordance and pursuant to the Act is final and binding on the parties, the fact that under the former provisions awards were final and binding suggest that the Act's awards would be construed similarly. *Gordon v. Tucker*, 6 Me. (6 GreenL.) 247 (1830).

Except where the grounds for opposing an arbitration award exist under Sections 5938 and 5939 or where the court declines to confirm an award on grounds other than those stated in Section 5938(1) (E) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties upon entry of judgment or decree by the court pursuant to Section 5937. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

g) Under the Act, grounds for judicial review are substantially identical to those of the UAA. More specifically, Section 5938 (Vacation of Award) and Section 5939 (Modification or Correction of Award) set forth grounds for judicial review of arbitration awards. Under the former arbitration provisions the only grounds for review of the referee's findings were fraud, prejudice or mistake. *Piscataquis Savings Bank v. Herrick*, 100 Me. 494, 62 A. 214 (1905).

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Given the enactment of Section 19 which provides that the Act shall be construed to make uniform the law of those states which enact it, the Maine courts would probably adhere to the logic of the Arizona courts which have pointed out that were they required to try each case de novo the reason for arbitration would be nugatory. See *Park Imperial, Inc. v. E.R. Tarmen Construction Co.*, 9 Ariz. App. 511, 454 P.2d 181 (1969).

i) With the exception of Section 5948, which excludes the Act's application from the resolution of disputes arising under a policy of automobile liability insurance for arbitration of a claim under the insured motorist coverage, there are no other peculiarities in the Act.

j) No provision of the Act prohibits its application to the settlement of personal injury claims.

k) Although it would appear that personal injury claims could be resolved under the Act, there have been no reported appellate court cases where the Act has been used to settle such a claim. Of course it should be recognized that the Act was only recently enacted and no appellate cases have been decided construing it.

l) In contrast to Maine's former arbitration provision under which contracts to settle future disputes were held null and void, *Dugan v. Thomas*, 79 Me. 221 (1887), Section 5927 of the Act provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there have been no reported appellate court cases where the act has been used to resolve personal injury claims, it would appear that, given the enactment of Section 5947 requiring the construction of the Act in accordance with other statutes modeled after the UAA, medical malpractice claims could be resolved under Maine's Act.

MARYLAND

I. STATUTORY FOUNDATION

Maryland has enacted an arbitration statute. *Md. Code Ann.*, Art. 7, Sections 1-23 (Repl. Vol. 1968); Art. 7, Section 12(b) (Cum. Supp. 1971); And see *Md. Code Ann.* Rules E1 to E5 (Cum. Supp. 1971) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

In 1965, the Maryland Legislature enacted its own Uniform Arbitration Act modeled after and substantially identical to the UAA. The Act differs from the UAA in the following respects: (1) Unlike UAA Section 1, the Maryland Act expressly provides that it is inapplicable to an arbitration agreement between employers and employees or between their respective representatives unless the agreement specifically states that the Act shall apply. Section 1; (2) The Maryland Act adds a clause providing for the making of a transcript of the proceedings which is absent from the UAA Section 7 counterpart. More specifically, Section (e) of the Maryland Act provides that: "The arbitrators may, and on application of either party shall, order that certain or all proceedings be transcribed and the record made therefrom shall be available to either side for the purpose of appeal or otherwise."; (3) The Maryland Act adds a provision absent from the UAA which sets forth the procedure for conducting arbitration upon the death or incompetency of a party who has agreed to submit a controversy to arbitration. Section 19; (4) The Maryland Act omits UAA section 15 providing for the preparation of the judgment roll; (5) Rule E3 of the Maryland Code provides that if the parties to any pending action, except an appeal from an administrative agency file a written request prior to trial that the action or any issue of the action be referred to arbitration for decision, the court is directed to order the action referred to arbitration which is to be conducted in accordance with the provisions of the Maryland Uniform Arbitration Act except where the court orders otherwise; (7) While UAA Section 12 affords aggrieved parties 90 days to apply to the court to vacate an award, Section 12(b) of the Maryland Act requires parties to apply within 30 days after the award; (8) Section 5(c), unlike its UAA counterpart, specifically provides that "The arbitrators shall not be bound by the technical rules of evidence."; and (9) Section 7(a) adds a sentence which states that "Any witness shall be sworn upon the request of any party or at the instance of a majority of the arbitrators."

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, Maryland's courts have continued to recognize the validity of common law arbitration. *See Chillum-Adelphi Volunteer Fire Dept., Inc. v. Button & Goode, Inc.*, 242 Md. 509, 219 A.2d 801 (1966).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 7(a) empowers arbitrators to issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 7(a) empowers arbitrators to administer oaths but does not require that oaths be administered before taking a witness' evidence. However, Section 7(a) further provides that a witness shall be sworn upon the request of any party or at the instance of a majority of the arbitrators.

c) Like UAA Section 5(a), Section 5(c) of the Maryland Act states that "The parties shall have the right to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing." In addition to these safeguards, Section 5(c) of the Maryland Act specifically provides that "The arbitrators shall not be bound by the technical rules of evidence."

d) Unlike the UAA, Section 7(d) of the Maryland Act makes a specific provision for the making of a transcript. It provides:

> The arbitrators may, and on application of either party shall, order that certain or all proceedings be transcribed and the record made therefrom shall be available to either side for purpose of appeal or otherwise.

e) Section 7(e) directs arbitrators to keep a record of the arbitration hearings upon the written request of either party.

f) Except where the grounds for opposing an arbitration award exist under Sections 12 and 13 or where the court declines to confirm an award on grounds other than those stated in Section 12(5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties upon entry of judgment or decree by the court pursuant to Section 11. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

In *Chillum-Adelphi Volunteer Fire Dept. v. Button & Goode, Inc.*, 242 Md. 509, 219 A.2d 801 (1966), arbitrators were authorized to determine whether the Fire Department's architect properly refused to extend the time for completion of construction by defendant contractor. Their award was challenged and a motion to vacate the award was made to the court.

After pointing out that an arbitration award is the decision of an extra-judicial tribunal which the parties have created and which the parties have agreed to accept as a binding determination of their controversy, the Supreme Court explained the grounds on which it could properly modify an award. First, the Court noted that it could modify an arbitration award for mistake of form, such as evident miscalculation of figures. But, the Court emphasized that while it was empowered to modify an award, it would not vacate or modify arbitrators' honest decisions for a mistake going to the merits of the controversy and resulting in an erroneous arbitration award, unless the mistake is so gross as to evidence misconduct or fraud by the arbitrators.

g) Grounds for judicial review are substantially identical to those of the UAA. More specifically, Section 12 (When court to vacate award) and Section 13 (When court to modify or correct award) set forth grounds for judicial review of arbitration awards.

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. *See Chillum-Adelphi, supra.* Moreover, given the enactment of Section 21 which provides that the Act shall be so construed to make uniform the law of those states which enact it, the Maryland courts would probably adhere to the logic of the Arizona courts which have pointed out that were the courts required to try each case de novo the reason for arbitration would be nugatory. *Park Imperial, Inc. v. E.R. Tarmen Construction Co.*, 9 Ariz. App. 511, 454 P.2d 181 (1969).

i) With the exception of Section 1 excluding the application of the Act to collective bargaining agreements to arbitrate, there are no other peculiarities in the Act.

j) No provision in the Act precludes its application to the settlement of personal injury claims.

k) Although it would appear that the Act could be applied to resolve personal injury claims, there have been no reported appellate court cases where such claims have been settled under the Act.

l) Section 1 provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBRITRATION POTENTIAL

In light of the enactment of Section 21 requiring the construction of the Act in accordance with other states which have enacted arbitration statutes modeled after the UAA, it would appear that medical malpractice claims could be resolved under Maryland's Act. *See e.g.*, Arizona analysis.

MASSACHUSETTS

I. STATUTORY FOUNDATION

Massachusetts has enacted an arbitration statute. *Mass. Gen. Laws Ann.* C. 251, Sections 1-19 (Supp. 1972) hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

In 1960, Massachusetts amended the General Laws by striking out Chapter 251, entitled "Arbitration", and by inserting in place thereof new Chapter 251 which is substantially identical to the UAA. The Act differs from the UAA in the following respects: (1) Unlike UAA Section 1 which specifically authorizes the application of the UAA to agreements between employers and employees or their respective representatives, Section 1 of the Massachusetts Act provides that "The provisions of this chapter shall not apply to collective bargaining agreements to arbitrate. . . . "; and (2) UAA Section 15 (Judgment Roll, Docketing), UAA Section 22 (Constitutionality), UAA Section 23 (Short Title) and UAA Section 24 (Repeal) were not adopted by the Massachusetts' legislature as part of its "Uniform Arbitration Act for Commercial Purposes".

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, Massachusetts courts continue to recognize the validity of common law arbitration. *United States ex rel. Industrial Eng. & Metal Fabricators, Inc. v. Eric Elevator Corp.* 214 F. Supp. 947 (D.Mass. 1943).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 7(a) empowers arbitrators to cause to be issued subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 7(a) empowers arbitrators to administer oaths but does not require that oaths be administered before taking evidence.

c) Section 5 states that "The parties shall have the right to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing." Beyond these safeguards, the Act is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

d) Although Section 8(a) requires that "The award shall be in writing and signed by the arbitrators concurring in the award," the Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act and case law are silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings or even on the keeping of a transcript.

f) Except where the grounds for opposing an arbitration award exist under Sections 12 and 13 or where the court declines to confirm an award on grounds other than those stated in Section 12(5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties upon entry of judgment or decree by the court pursuant to Section 11. *Glenn Acres, Inc. v. Cliffwood Corp.*, 353 Mass. 150, 228 N.E. 2d 835 (1967). Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

In *McGovern v. Middlesex Mut. Ins. Co.*, 269 N.E. 2d 445 (1971), the Supreme Court of Massachusetts held that in the absence of fraud, an arbitration award is binding on the parties notwithstanding the fact that the arbitrators may have committed an error of law or fact in reaching its decision. See also *Glenn Acres, Inc. v. Clifford Corp.* 353 Mass. 150, 228 N.E. 2d 835 (1967).

Moreover, in *Fazio v. Employers' Liability Assur. Corp.* 346 Mass. 645, 197 N.E. 2d 598 (1964), the Court held that an arbitration award could not be impeached because arbitrators did not provide a statement as to why a claim was denied or because the findings of fact and conclusions of law on which the award was based was not given by the arbitrators. See also *Fidelity & Cas. Co. of New York v. Cooke*, 256 N.E. 2d 447 (1970); Note, *Judicial Review of Arbitration Awards on the Merits*, 63 *Harv. L. Rev.* 681 (1950).

g) Grounds for judicial review are substantially identical to those of the UAA. Section 12 (Vacation of award; grounds; time for application; rehearing; confirmation) and Section 13 (Award; modification by court; time for application; grounds; joinder with application to vacate) set forth grounds for judicial review of arbitration awards.

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Given the enactment of Section 19 which provides that the Act shall be so construed to make uniform the law of those states which enact it, the Massachusetts courts would probably adhere to the logic of the Arizona courts which have pointed out that were the courts required to try each case de novo the reason for arbitration would be nugatory. *Park Imperial, Inc. v. E.R. Tarmen Construction Co.*, 9 Ariz. App. 511, 454 P.2d 181 (1969).

i) With the exception of Section 1 excluding the application of the Act to collective bargaining agreements to arbitrate, there are no other peculiarities in the Act.

j) No provision in the Act precludes its application to the settlement of personal injury claims.

k) Notwithstanding the name "Uniform Arbitration Act for Commercial Disputes", the Act has been used to resolve uninsured motorist coverage disputes.

l) Section 1 provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given the resolution of uninsured motorist coverage and the enactment of Section 19 requiring the construction of the Act in accordance with other states which have enacted arbitration statutes modeled after the UAA, it would appear that medical malpractice claims could be resolved under Massachusetts' act. *See e.g.*, Arizona analysis.

MICHIGAN

I. STATUTORY FOUNDATION

Michigan has enacted an arbitration statute. *Mich. Comp. Laws Ann.* Sections 600.5001 to 600.5035 (1964); *Mich. Ct. Rules Ann.* Rule 769 (1964) (hereinafter Act and Rule).

II. RELATIONSHIP OF STATUTE TO UAA

The Michigan Act is modeled after the UAA. However, while it contains the substance of the UAA, the Act also has numerous variations, omissions and additional matter. Differences between the Michigan Act and the UAA are indicated in the analysis of "procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, Michigan's courts have continued to recognize the validity of common law arbitration. *Manausa v. Saint Paul Fire & Marine Ins. Co.*, 356 Mich. 629, 97 N.W.2d 708 (1959). However, unlike statutory arbitration which guarantees parties the right to submit controversies to arbitration, there is no common law right to arbitration which a party could assert to compel arbitration of a dispute. *International Union, United Auto Aircraft v. Benton Harbor Mal. Ind.*, 242 F.2d (6th Cir. 1957), *cert. denied*, 355 U.S. 814 (1957).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Rule 769.5(1) states that Rule 506 applies to arbitration hearings. Rule 506 does not empower arbitrators to cause to be issued subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence. Rather, it provides that the court, not the arbitrators, can issue, at the request of any party, subpoenas to compel the attendance of witnesses and the production of books, records, documents and other tangible things.

b) Rule 769.4 empowers arbitrators to administer all necessary oaths to witnesses before them but does not require that oaths be administered before taking evidence. Furthermore, Rule 769.4 requires that arbitrators, before proceeding to hear any testimony, swear an oath to faithfully and fairly hear and examine and decide the matters in controversy.

c) Unlike UAA Section 5(b) which states that "The parties shall have the right to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing", the Michigan Act is silent as to these safeguards. On the other hand, the Michigan Act, like the UAA, guarantees the parties the right to counsel at the hearings. Rule 769.6.

While the Michigan Act is silent as to the right to be heard, present evidence and cross-examine, the Michigan courts have made it clear that these rights are an integral part of the Michigan Act and a prerequisite to any valid arbitration.

In *Dewey v. Reynolds Metals Co.*, 291 F. Supp. 786 (Mich. 1968), the Federal District Court, applying Michigan law, emphasized that the rules of due process, including the right to present evidence and cross-examine witnesses, as well as other constitutional protections must be extended to arbitration proceedings and that proceedings devoid of such protections are a nullity.

d) The Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

Moreover, it should be noted that absent from the Michigan Act is UAA Section 8 which expressly requires that an award shall be in writing and signed by the arbitrators joining in the award. However, like the UAA, the Michigan Act authorizes the majority of the arbitrators to conduct the hearing and render a final award, unless the concurrence of the arbitrators is expressly required in the submission.

e) The Act and case law are silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings or even on the keeping of a transcript.

f) Except where the grounds for opposing an arbitration award exist under Rules 769.9 and 769.10 or where the court declines to confirm an award on grounds stated in these rules and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties upon entry of judgment or decree by the court pursuant to Section 11. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

In *Hatfield v. Safeco Ins. Co.*, 31 Mich. App. 671, 188 N.W.2d 45 (1971), the Michigan Appellate Court announced the rule, well recognized in Michigan, that in reviewing an arbitration award a court may not substitute its own judgment for that of the arbitrators. And, in *Rushton v. Howard Sober, Inc.*, 198 F. Supp. 337 (D. Mich. 1961), the Federal District Court pointed out that under Michigan law parties to an arbitration are conclusively bound by its award until it is set aside in an action directly attacking its legality. See also *Toledo S.S. Co. v. Zenith Transp. Co.*, 184 F. 391 (6th Cir. 1911).

g) Grounds for judicial review are substantially identical to those of the UAA. Rule 769.9 (Vacating an Award) and Rule 769.10 (Modification or Correction of Award) set forth grounds for judicial review of arbitration awards.

Announcing the State's policy under a former arbitration statute, the Supreme Court of Michigan stated that: (1) the courts are not inclined to interfere with the arbitrators' methods of reaching a decision or to bind them "to the nice rules of pleading," evidence and precedents; (2) the courts would not review the submitted controversy on the merits or disturb the award for any error which was not the product of fraud. *Chicago & Mich. Lake Shore R.R. Co. v. Hughes*, 28 Mich. 186 (1873).

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Although the Michigan Legislature did not enact a section providing that the Act shall be construed so as to make uniform those states which enact the UAA, the Michigan courts have consistently stated that they will not review the subject matter of an arbitrator. See, *e.g.*, *Chicago & M.L.S.R. Co. v. Hughes*, 28 Mich. 186 (1873).

In *Frazier v. Ford Motor Co.*, 364 Mich. 648, 112 N.W.2d 80 (1962), the Supreme Court of Michigan noted that an arbitration award, whether by common law or by statute, bars recourse to the courts for judicial determination of the dispute, so long as the presumptively valid award is permitted to stand.

Not only have the Michigan courts refused to hear de novo the merits of a controversy submitted to arbitration but they have refused to allow parties to bring an action where the parties have agreed to submit controversies to arbitration. Enforcing the Michigan law, the Federal Court of Appeals in *Van Horn v. State Farm Mutual Automobile Ins. Co.*, 391 F.2d 910 (6th Cir. 1968), affirmed the District Court's motion to dismiss plaintiff-insured's action on the ground that the matter had not been submitted to arbitration as required by the terms of his insurance policy.

In *Van Horn*, plaintiff sued his insurance company to recover under his uninsured motorist coverage clause damages he incurred when he was involved in an accident with a driver who carried no insurance. Affirming the District Court's dismissal of the action and impliedly recognizing the validity of the insurance company's defense, the Court held that under Michigan law the plaintiff could not maintain an action to recover damages until the claim was submitted to arbitration in accordance with the arbitration provisions of the automobile liability policy.

i) The Act is peculiar in that it is not consolidated in a single section of Michigan's Compiled Laws. Rather, the portions of the Act which embody the substance of the UAA are set forth in rules 769. Matters extraneous to the UAA are found in the Compiled Laws, sections 600.5001 to 600.5035.

j) No provision of the Act precludes its application to the settlement of personal injury claims.

k) Although it would appear that the Michigan Act can be applied to resolve personal injury claims, there have been no reported appellate court cases where such a claim has been resolved under the Act. However, in *Van Horn*, *supra*, the court impliedly recognized the validity of resolving personal injury claims through arbitration by affirming the dismissal of an injured insured's action for failure to submit to arbitration in accordance with the terms of his policy.

Moreover, in *Waldrop v. Rodery*, 34 Mich. App. 1, 190 N.W. 2d 691 (1971), the Court affirmed the judgment entered on an arbitration award requiring the insurer to pay plaintiff, in addition to damages for personal injuries sustained in an automobile accident, administrative fees and interest.

In *Waldrop*, plaintiff commenced an action against defendant-insured, but subsequently agreed with defendant's insurer to submit the personal injury claim to arbitration under the Accident Claims Tribunal Rules of the American Arbitration Association (AAA). Before the award and administrative fees and interest were paid, a judgment was entered on the award, and insurer appealed the inclusion of the court costs, AAA fee and interest charge.

Concluding that plaintiff did not waive interest and court costs and that it was for the arbitrator to decide whether interest and court costs would be included, the

Court affirmed the judgment on the award. The case is instructive for it would seem that if the Michigan Courts recognize the resolution of personal injury claims under the rules of the AAA in their State, it would seem likely that the Courts would give credence to similar arbitrations under the Act.

1) Section 600.5001(1) provides that an instrument in writing to submit an existing dispute to arbitration is valid. Furthermore, Section 600.5001(2) expressly provides that a provision in a written contract to settle by arbitration a controversy subsequently arising out of the controversy is valid, enforceable and irrevocable save upon such grounds as exist at law or in equity for the rescission or revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given the fact that it has been impliedly recognized that personal injury claims may be resolved by arbitration under the Act, and given the absence of any provision prohibiting the resolution of medical malpractice claims under the Act, it would appear that medical malpractice claims could be resolved under the Act.

MINNESOTA

I. STATUTORY FOUNDATION

Minnesota has enacted an arbitration statute. *Minn. Stat. Ann.* Sections 572.08 to 572.30 (Cum. Supp. 1972) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

In 1957, the Minnesota Legislature repealed its arbitration provisions and enacted the Minnesota Uniform Arbitration Act. The Act is modeled after and is substantially identical to the UAA in all material respects.

III. COMMON LAW ARBITRATION

The Minnesota Uniform Arbitration Act, like the former arbitration provisions, is not in derogation of the common-law. Consequently, the Minnesota courts have continued to recognize the validity of and to give effect to common law arbitration. *Zelle v. Chicago & N.W.R. Co.*, 242 Minn. 439, 65 N.W.2d 583 (1954).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 572.14(a) empowers arbitrators to issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 572.14(a) empowers arbitrators to administer oaths but does not require that arbitrators administer oaths before taking testimony.

c) Section 572.12(b) states that "The parties are entitled to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing." Beyond these safeguards, the Act is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

In addition to the Act's silence as to the necessity of conducting arbitration hearings in accordance with strict evidentiary rules, the Minnesota court's recognition that the purpose of the Act is to discourage litigation and foster voluntary resolution of disputes in a forum created, controlled, and administered by the parties' written agreement, suggests that strict evidentiary rules, need not be followed in arbitration hearings. *Layne-Minnesota Co. v. Regents of University of Minn.*, 266 Minn. 284, 123 N.W. 2d 371 (1963).

d) Although Section 572.15(a) requires that "The award shall be in writing and signed by arbitrators joining in the award," the Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act and the case law are silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings or even on the keeping of a transcript.

f) Except where the grounds for opposing an arbitration award exist under Sections 572.19 and 572.20 or where the court declines to confirm an award on grounds other than those stated in Section 572.19 subd. 1(5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

In *Layne-Minnesota Co. v. Regents of University of Minn.*, 266 Minn. 284, 123 N.W. 2d 371 (1963), the scope of a contract provision permitting arbitration became the subject of dispute. The arbitrators determined that a contractor's claim for additional compensation was contemplated by the contract. In reviewing the award, the Court emphasized that contracting parties may narrowly limit arbitration of future controversies or may comprehensively provide that all disputes, whether arising under cognizable or not in a court of law or equity, may be referable to arbitration.

In *Fischer v. Guaranteed Concrete Co.* 276 Minn. 510, 151 N.W. 2d 266 (1967), the Court held that the arbitrators are the final judges of law and fact and that mistakes of law by the arbitrators are not the basis for judicial review.

g) Grounds for judicial review are substantially identical to those of the UAA. More specifically, Section 572.19 (Vacating an award) and Section 572.20 (Modification or correction of award) set forth grounds for judicial review.

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Rather the courts can confirm, modify or vacate the award or order a rehearing under the Act. It would appear that the Minnesota courts which have recognized that the Act was designed to provide a quick and inexpensive form of settling controversies, would also recognize that were the courts to hear arbitration disputes de novo the reason for arbitration would be nugatory.

i) There are no peculiarities in the Act as drafted or construed.

j) No provision in the Act precludes its application to the settlement of personal injury claims.

k) Although it would appear that the Act could be used to resolve personal injury claims, there has been no reported appellate court cases where the Act has been used to resolve such a claim. However, it is noteworthy that in *Niazi v. St. Paul Mercury Ins. Co.*, 265 Minn. 222, 121 N.W. 2d 349 (1963), a dispute arising under an uninsured motor vehicle insurance clause involving a claim for medical expenses was resolved by arbitration pursuant to the Act.

l) Section 572.08 provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there are no reported appellate cases where medical malpractice claims have been resolved pursuant to the Act, it would appear that a medical malpractice claim could be settled under the Act.

Support for this tentative conclusion can be garnered from the Minnesota courts recognition that arbitration is designed to quickly and inexpensively resolve controversies whether or not cognizable in a court of law or equity. Moreover, as the Minnesota Legislature enacted Section 572.28 providing for the uniformity of construction of the Act, it would appear that medical malpractice claims could be resolved under the Act. *See, e.g.*, Arizona analysis.

MISSISSIPPI

I. STATUTORY FOUNDATION

Mississippi has enacted an arbitration statute. *Miss. Code Ann.* Tit. 3, Sections 279-297 (1942).

II. RELATIONSHIP OF STATUTE TO UAA

The Mississippi statute, a direct descendant of an 1892 Act, is neither modeled after nor similar to the UAA. Differences between the two are substantial. Particularly noteworthy is the Mississippi statute's requirement that witnesses testifying before arbitrators be sworn. Moreover, the Mississippi statute is only applicable to the resolution of existing disputes. Other dissimilarities between the Mississippi statute and the UAA are indicated in an analysis of the "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

The Mississippi courts also have continued to recognize the validity of a given effect to common law arbitration awards. Indeed, Section 297 of Mississippi's arbitration statute expressly preserves the validity of common-law arbitration awards. *See McClendon v. Shutt*, 237 Miss. 703, 115 So.2d 740 (1959).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Although Mississippi's arbitration statute does not empower arbitrators to issue subpoenas, Section 285 provides that ". . . the parties shall have the benefit of legal process to compel the attendance of witnesses, which may be issued by the clerk of any court or a justice of the peace, and shall require the witness to attend before the arbitrators on a day and a place certain to be named in the subpoena." Furthermore, Section 286 states: "The sheriff, constable or any person agreed upon in writing by the parties, may execute process returnable before arbitrators."

Like UAA Section 7(a), which provides that upon application to the court by the parties or the arbitrators to enforce subpoenas the court may apply enforcement procedures applicable in a civil action, Section 287 prescribes a penalty punishable as contempt of court for "any person duly subpoenaed to appear before the arbitrators and testify".

b) Testimony by witnesses at arbitration hearings is given under oath. Section 285 requires that "All witnesses before arbitrators shall be sworn as if before a court . . . . " Moreover, arbitrators must be sworn before assuming their duties. Section 283.

c) While Section 284 requires, in the absence of a mutual waiver in writing by the parties, that the arbitrators meet together and hear all of the allegations and evidence of the parties pertinent or material to the cause, the Act is silent as to whether arbitration proceedings must be conducted in accordance with strict evidentiary rules.

Although the statute is silent as to whether strict evidentiary rules must be adhered to in the conduct of arbitration proceedings, the Mississippi courts have held that arbitrators need not observe strict evidentiary rules. Speaking on this point, the Supreme Court of Mississippi said that the arbitrators "might proceed altogether on views of what was right and just between the parties without following either the rules that would govern a court of law or equity in the circumstances." *Hutto v. Jordan*, 204 Miss. 30,32,36 So. 2d 809, 811 (1948).

d) Although Section 288 requires, before an award can be forced, that the award be made in writing and signed by the concurring arbitrators, the statute is silent as to whether a transcript of the arbitration proceeding must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The statute is silent as to whether reporters may be brought to the arbitration proceedings. It would appear, however, that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present or even that the arbitrators keep a transcript of the proceedings.

f) Like the UAA, the Mississippi statute provides that where an award is rendered in compliance with the statutes it is a final and binding determination of the controversy which may not be disturbed unless statutory grounds exist. In short, valid arbitration awards constitute a final and binding determination of that issue and precludes a de novo determination of that issue by the courts or by a subsequent arbitration notwithstanding the fact that a mistake of law or fact has been made. *Hutto v. Jordan*, 204 Miss. 30, 36 So. 2d 809 (1948).

g) Grounds for judicial review are very similar to those of the UAA. More specifically, an award may be vacated on the grounds stated in Section 290 of the Mississippi statute which is substantially identical to Section 12(a) of the UAA. Mississippi's arbitration Section 291 which specifies the grounds for which an award may be modified or corrected, closely parallels the grounds set out in UAA Section 13. Section 293 of Mississippi's arbitration statute is similar to UAA Section 12(c) which provides that the court may, in vacating an award, order a new hearing by the arbitrators if their agreement permits. Finally, Section 289 of the Mississippi statute specifying the method by which an award is to be confirmed by the court is similar to UAA Section 11.

While the Mississippi courts may remand the proceedings to the arbitrators when it vacates their award, the Mississippi statute does not authorize the courts to appoint arbitrators if for any reason the parties' method of appointing arbitrators fails, as does UAA Section 3.

The absence of a provision analogous to UAA Section 3 authorizing court appointment of arbitrators might have an adverse effect on arbitration in Mississippi. Section 279 provides in part that "persons . . . [may] submit to the decision of one or more arbitrators any controversy" between them and agree that a court shall render judgment on the award. Because of the absence of a provision authorizing court appointment of arbitrators, it would appear that an agreement which fails to provide a method of selecting arbitrators or provides a method which fails would, in effect, invalidate the agreement to arbitrate.

h) As previously indicated in the analysis of Question IV (f) an award rendered in compliance with the statute's requirements is a final and binding determination of the issue submitted and precludes a de novo determination of that issue.

i) The Mississippi statute is peculiar in that it has been construed so as to preserve the common-law rule that either party may revoke an agreement to submit to arbitration at any time before an award has been made.

In the recent case of *McClendon v. Shutt*, 237 Miss. 703, 115 So.2d 740 (1959), the Supreme Court of Mississippi emphasized:

> Our statute on Arbitration and Award, Section 279, Code of 1942, recognizes the right of the parties to submit their disputes to arbitration, but in our opinion this statute does not attempt to abrogate the common law rule to the effect that either party may revoke an agreement to submit to arbitration at any time before an award has been made.

McClendon v. Shutt, *supra*, 237 Miss. at 704, 115 So.2d at 741.

This rule permitting either party to revoke an agreement to submit to arbitration at any time before the award has been made is in marked contrast to UAA Section 1 which provides in part that "a written agreement to submit any existing controversy to arbitration . . . is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract." Moreover, Mississippi's rule permitting the revocation of an agreement to submit to arbitration before the award is rendered is in contrast to other states' arbitration statutes which are not modeled after the UAA.

j) No provision of the Mississippi arbitration statute precludes its application to the settlement of personal injury claims.

k) Although it would appear that personal injury claims could be resolved under Mississippi's statute, there have been no reported appellate cases where the statute has been used to resolve a personal injury claim.

l) Section 279 expressly provides that agreements to arbitrate existing disputes are valid under the statute. In pertinent part, it states: "All persons . . . may, by instrument of writing, submit to the decision of one or more arbitrators any controversy *which may be existing between them,* which might be the subject of an action . . . ." There is no similar provision recognizing the validity of agreements to submit future disputes to arbitration. (Emphasis added).

Although it could be inferred from the express validation of agreements to submit existing disputes to arbitration and the absence of any provision recognizing the validity of an agreement to submit future disputes to arbitration, Mississippi case law suggests that agreements to submit future disputes to arbitartion are valid.

In *Standard Mill Work and Supply Co. v. Mississippi Steel & Iron Co.*, 205 Miss. 96, 38 So.2d 448 (1949), the Supreme Court of Mississippi recognized the parties' right to revoke a written agreement to submit to arbitration before an award is made. Significantly, the contract construed by the Court contained a provision for submitting all disputes, claims or questions *arising under* the contract to arbitration. Nothwithstanding this provision, the Court did not suggest that the provision was invalid under Mississippi law as an attempt to oust the court's jurisdiction or that it was invalid for any other reason.

Furthermore, Section 297 provides in part that the statute "shall be liberally construed for the encouragement of the settlement of disputes and the prevention of litigation."

In conclusion, the case law and the Court's announced policy to liberally construe the statute to encourage settlement of disputes by arbitration suggest that agreements to arbitrate disputes arising out of contracts are valid.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given the fact that the State's policy is to permit arbitration and to give effect to a valid submission, and given the broad language of Section 279 which provides that parties may submit "any controversy" to arbitration, it would seem that medical malpractice disputes could be arbitrated under the Act.

MISSOURI

I. STATUTORY FOUNDATION

Missouri has enacted an arbitration statute. *Mo. Rev. Stat. Ann.* Sections 435.010 to 435.280 (Vernon 1959).

II. RELATIONSHIP OF STATUTE TO UAA

Although the Missouri arbitration statute is not modeled after the UAA it is similar in several respects. Most importantly, like the UAA, it sets forth procedures for the conduct of a hearing, the making of an award by the arbitrators, the vacating, modifying and correcting of an award by the court, and the empowering of arbitrators. Dissimilarities between the Missouri arbitration statute and the UAA are indicated in the analysis of "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, Missouri's courts have continued to recognize the validity of and give effect to common law arbitration. *Masonic Temple Ass'n. of St. Louis v. Farrar*, 422 S.W.2d 95 (Mo. App. 1967).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 435.040 empowers arbitrators to subpoena witnesses to attend hearings. It states in pertinent part: "The arbitrators shall have the same power to issue subpoenas for witnesses and to compel their attendance by attachment, . . . and punish contempts committed in their presence during the hearing of the cause, that may be given by the law to the magistrates."

b) Section 435.040 empowers arbitrators to administer oaths. It states in part that "The arbitrators shall have the same power . . . to administer oaths . . . that may be given by law to magistrates. While this language is not mandatory in the sense that arbitrators are required to administer oaths before hearing evidence, the Supreme Court of Missouri held, in construing a substantially identical predecessor provision, that it is the duty of the arbitrators to require witnesses to testify under oath and that where the requirement of an oath has not been waived by the "defeated" party, the award is a nullity. *Wolfe v. Hyatt*, 76 Mo. 156 (1882). See generally Hensley, *Arbitration in Missouri*, 13 Mo. L. Rev. 170 (1948).

To the same effect as *Wolfe* and directly supporting the proposition that arbitrators must administer oaths to witnesses is *Redman v. St. Joseph Hay & Grain Co.*, 209 Mo. App. 682, 239 S.W. 540 (1922). In *Redman*, the Court of Appeals held that the failure of the arbitrators and of the witnesses before them to subscribe to an oath, as required by Sections 435.030 and 435.040, rendered the award void. See also *Rickman v. White*, 266 S.W. 997 (Mo. App. 1924.) It should be noted, however, that the parties may waive the necessity of swearing in witnesses. *Cochran v. Bartle*, 91 Mo. 636, 3 S.W. 854 (1887).

c) Although the Missouri arbitration statute is silent as to whether arbitration proceedings must be conducted in accordance with strict evidentiary rules, the Missouri courts have declared that arbitrators are not bound by rules of evidence and that they can consider testimony which would be impermissible in a court of law. *Masonic Temple of St. Louis v. Farrar*, 422 S.W. 2d 95 (Mo. App. 1967).

In *Shawhan v. Baker*, 167 Mo. App. 25, 150 S.W. 1096 (1912), the Court of Appeals was discussing grounds for modifying, correcting and vacating an arbitration award. It explained that in the construction of Section 435.100 (Award, how vacated and for what causes) and Section 435.110 (Award, how modified and corrected):

"The courts of this state have adhered to the doctrine of . . . that, where the parties select their own tribunal, they are bound to submit to the consequences of their choice, and the defeated party will not be heard to complain to the courts, and invoke their aid, when the wrongs of which he complains are merely errors that might be expected to characterize the judgments of judges untrained in the law. As is said by Bakewell, J., in his very able opinion in Mitchell v. Curran, 1 Mo. App., [453 at] 457: 'It is too late for those who, for the purposes of economy, or to save time, or for any other laudable motive, have chosen to submit a controversy, absolutely to *a tribunal which is not bound by legal rules*, to invoke the protection of those despised rules when mischief has been worked by the disregard of them.' " *Shawhan v. Baker*, *supra*, 167 Mo. App. at 34, 150 S.W. at 1098-1099.

To the same effect as *Shawhan*, with regard to the question whether arbitrators must conduct hearings in accordance with strict evidentiary rules, is *Reily v. Russell*, 34 Mo. 524 (1864). In *Reily*, the Supreme Court of Missouri held that (1) an arbitration tribunal is not required to conduct in accordance with the rules of evidence, and (2) that unless partiality or corruption, gross miscalculation in a matter of figures, or decision in a matter not submitted is shown, the courts cannot interfere with the arbitrators' award.

d) Although Section 435.070 requires that an award be made in writing and subscribed by the concurring arbitrators, the statute is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept suggests that the parties need not keep a transcript. However, it could be inferred from cases that the parties may agree to have a transcript compiled as a condition of their agreement to arbitrate. *See Sweeney v. Vaundry*, 2 Mo. App. 352 (1876).

e) The statute is silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings.

f) Except where the grounds for opposing an arbitration award exist under Sections 435.100 and 435.110, it is final and binding on the parties upon entry of judgment by the court pursuant to Section 435.150. *Masonic Temple of St. Louis v. Farrar*, 422 S.W.2d 95 (Mo. App. 1967); and see Question IV (c), *supra*.

While arbitration awards are final and binding on the parties, no provision of the statute authorizes the courts to compel a party to submit to arbitration in accordance with his written agreement. However, Section 435.250 provides that whenever a submission to arbitrate shall be revoked by a party, the party refusing to arbitrate is made liable to the other party to recover all costs, expenses and damages, including attorney fees, in preparing for the arbitration. Furthermore, Section 435.250 prohibits the revocation of an agreement to arbitrate after the controversy has been heard by the arbitrators.

g) Grounds for judicial review similar to those of the UAA are set forth in Sections 435.100 and 435.110.

h) The Statute does not provide for a trial de novo of the subject matter of the arbitration. In *Pope Construction Co. v. State Highway Commission*, 337 Mo. 30, 84 S.W.2d 920 (1935), the Supreme Court of Missouri construed a substantially identical predecessor of Section 435.130 which provides that the court may vacate an award as specified by the statute, or direct a rehearing by the arbitrators. It held that on a motion to vacate an award, courts may only determine whether the award was vitiated by any conditions of the statute and cannot adjudicate the merits of the controversy. In so holding, the Court stated: "If the award is vacated, no proceeding remains pending in the courts and the parties to the controversy are in the same position in reference thereto that they were before they entered into the arbitration pact." *Pope Construction Co., supra*, 337 Mo. at 32, 84 S.W.2d at 921.

i) The Missouri statute is unusual in that Section 435.010 makes unenforceable between the parties any requirement for arbitration. It states:

> Any contract or agreement . . . containing any clause or provision for an adjustment by arbitrators shall not preclude any party or beneficiary under such contract or agreement from instituting suit or other legal action on such contract at any time, and the compliance with such clause or provision shall not be a condition precedent to the right to bring or recover in such arbitration.

Construing this section the Court in *Ewing v. Pugh*, 420 S.W.2d 14, 19 (Mo. App. 1967) said:

> An arbitration agreement under the statute is not void, but only voidable at the behest of either party. The statute does not declare any such agreement to be void. It says, rather, any such agreement "shall not preclude any party or beneficiary" from instituting a suit.

j) No provision of the statute precludes its application to the resolution of personal injury claims.

k) Although it would appear that the statute could be used to resolve personal injury claims, there have been no reported appellate court cases where it has been used to settle such disputes.

l) Section 435.020 expressly recognizes the validity of agreements to settle existing disputes. In pertinent part, it states: All persons . . . may, by instrument of writing, submit to the decision of one or more arbitrators any controversy which may be existing between them, which might be the subject of an action . . . . " There is no similar provision recognizing the validity of agreements to submit controversies arising out of contracts to arbitration.

In *Bales v. Gilbert*, 84 Mo. App. 675 (1900), the Court held that the courts could not be ousted of their jurisdiction over actions between parties by agreements to submit future controversies to arbitration.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Notwithstanding the absence of case law involving the resolution of personal injury claims under the statute, it would appear, given the absence of any provision prohibiting the resolution of medical malpractice claims and the broad scope of Section 435.020 which provides that "any controversy" may be submitted to arbitration, that existing medical malpractice claims could be resolved under Missouri's arbitration statute. The statute, however, would be inapplicable to agreements to arbitrate future medical malpractice disputes arising out of contracts. *See* IV 1, *supra.*

MONTANA

I. STATUTORY FOUNDATION

Montana has enacted an arbitration statute. *Mont. Rev. Stat. Ann.* 93-201-1 to 93-201-10 (1947).

II. RELATIONSHIP OF STATUTE TO UAA

The Montana arbitration statute is substantially identical to that of Idaho. Similarly, Montana's statute lacks much of the operative detail of the UAA. There are no provisions for: (1) choosing an arbitrator; (2) guaranteeing the right to the presence of counsel at hearings; (3) changing the award; (4) allocating fees and expenses; (5) specifying a method of delivery of the award; and (6) staying the arbitration proceedings. Furthermore, there is a difference regarding the availability of appellate review.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, common law arbitration is recognized in Montana. *Carlston v. St. Paul Fire & Marine Ins. Co.*, 37 Mont. 118, 94 P. 756 (1908).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) No provision of Montana's arbitration statute clothes arbitrators with the power to subpoena witnesses or books, records, documents or other evidence.

b) Section 93-201-4, specifying the powers of arbitrators, empowers arbitrators to administer oaths to witnesses, but does not require arbitrators to administer oaths before hearing the testimony of the parties and witnesses. On the other hand, Section 93-201-5 requires arbitrators to be sworn by an officer authorized to administer oaths before assuming their duties.

c) Both Montana's arbitration provisions and case law are silent as to whether strict evidentiary rules are observed in arbitration proceedings.

d) Montana's statute is silent as to whether a transcript of the arbitration proceedings must be kept, and there have been no Montana court decisions requiring the making of a transcript or invalidating an award for want of a transcript.

e) Montana's statute and case law are silent as to whether the parties may agree to bring a reporter to the arbitration proceedings. However, it would seem that the parties could condition their agreement on the presence of a reporter at the arbitration proceedings or the making of a transcript of the proceedings.

f) An award is final and binding on the parties where the stipulation calls for it to be entered as an order of the court. Section 93-201-6. There is a five-day period between the filing of the award with the clerk of the court and its becoming final. If judgment is entered before a motion to vacate, modify or correct the award is made, it is not appealable. The motions referred to above are applicable, however.

g) Section 93-201-7 provides that a motion to vacate may be based on allegations of fraud in procuring the award or on allegations of misfeasance or malfeasance by the arbitrators. A motion to modify or correct the award may be made for a clerical mistake on its face; where a decision was made on an issue not submitted to arbitration and that issue is functionally separable from the issues properly submitted; or, where the error in form could have been corrected had the award been a verdict. Section 93-201-8; *Hopkins v. School Dist. No. 40,* 133 Mont. 530, 327 P.2d 395 (1958); *McIntosh v. Harford Fire Ins. Co.,* 106 Mont. 434, 78 P.2d 82 (1938).

h) Appeals from special proceedings are subject to the Rules of Civil Procedure which do not permit a trial de novo on appeal. *Mont. R. Civ.* P. 72; 81(a); *Pope v. Alexander*, 36 Mont. 82, 92 P. 203 (1907).

i) The Montana statute is peculiar in that questions relating to the title of real property are excluded from the ambit of arbitration by Section 93-201-1.

j) No provision in Montana's arbitration statute makes it inapplicable to the settlement of personal injury claims.

k) A review of the case law construing Montana's arbitration provisions does not reveal any reported appellate court case where arbitration was used to settle a personal injury claim.

l) The Montana statute has been interpreted as contemplating only the submission of pre-existing disputes to arbitration. *Green v. Wolff,* 140 Mont. 413, 372 P.2d (1962).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

While there are no reported appellate cases indicating that Montana's arbitration statute has been used to settle personal injury claims, Section 93-201-1 provides that parties capable of contracting may submit any controversy to arbitration. Thus, it would seem that Montana's arbitration statute could be used to settle medical malpractice claims. However, it should be recognized that judicial construction has limited the application of the statute to existing disputes. *See Carlston v. St. Paul Fire & Marine Ins. Co.*, 37 Mont. 118, 94 P.756 (1908).

NEBRASKA

I. STATUTORY FOUNDATION

Nebraska has enacted an arbitration statute. *Neb. Rev. Stat.* Sections 25-2103 to 25-2120 (1943). See also *Neb. Rev. Stat.* Sections 25-1129 to 25-1137 (1943) (trial by referee).

II. RELATIONSHIP OF STATUTE TO UAA

The Nebraska arbitration statute antedates the formulation of the UAA and bears little similarity to it.

Generally, the Nebraska statute is far less comprehensive than the UAA. Procedural guidelines for the conduct of hearing and the grounds for vacating, modifying and correcting awards are not set forth in detail as in the UAA. Moreover, the Nebraska statute's application to the resolution of controversies arising out of contracts is limited to controversies arising out of a contract with the Nebraska Department of Roads. Further dissimilarities between the Nebraska statute and the UAA are indicated in the analysis of the "Procedural Attributes of the Statute." (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Nebraska courts have continued to recognize the validity of common law arbitration. *Burkland v. Johnson*, 50 Neb. 858, 70 N.W. 388 (1897).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 25-2108 provides that the rules regulating the conduct of referees are applicable to arbitrators. It states: "All the rules prescribed by law in cases of referees are applicable to arbitrators except as herein otherwise expressed or except as otherwise agreed upon by the parties."

The Nebraska arbitration statute does not directly empower arbitrators to issue subpoenas. Therefore, the provision empowering referees, incorporated by Section 25-2108, would appear to be applicable to arbitrators. Since Section 25-1131 provides that referees have the same power to summon or enforce the attendance of witnesses as the courts, it would also empower arbitrators to subpoena witnesses.

b) As indicated in Question IV (a), the rules applicable to arbitrators are the same as those prescribed for referees except where the arbitration statute or the parties' agreement otherwise provides. The arbitration statute is silent as to the arbitrators' power to administer oaths. However, the rule prescribed by Section 25-1131 states that referees have the same power to administer all necessary oaths as the Nebraska courts. This rule is incorporated by reference by Section 25-2108 and, therefore, arbitrators are empowered to administer oaths to witnesses testifying before them.

Although the language empowering the referees to administer oaths does not expressly require the administration of an oath before taking evidence, it would appear that testimony at arbitration hearings must be given under oath because Section 25-1131 requires that trial before referees be conducted in the same manner as a trial by the court.

Section 25-1131 provides in part that "The trial before referees is conducted in the same manner as a trial by the court." Since witnesses testify under oath at trials conducted by the courts and since the arbitration statute is silent as to the administration of oaths, it would appear that witnesses testifying at arbitration hearings are under oath.

c) The Nebraska arbitration statute is silent as to whether strict evidentiary rules are observed in the conduct of arbitration proceedings. Consequently, the rules regulating referees which are incorporated and made applicable to arbitrators by Section 25-2108 control. Section 25-1131, which prescribes the procedure to be followed by referees, states that: "The trial before the referees is conducted in the same manner as a trial by the court . . . They must state the facts found and the conclusions of law, separately, and their decision must be given . . . . "

As trials are conducted by courts in accordance with strict evidentiary rules, it would appear that the rule requiring referees to conduct their tribunal in the same manner as the court would also apply to arbitrators by virtue of the adoption of the rules regulating referees made by Section 25-2108.

Not only do canons of statutory construction suggest the conclusion that strict evidentiary rules are made applicable to the conduct of arbitration hearings by the incorporation of the rules regulating referees, but the Nebraska courts' holdings suggest that adherence to evidentiary rules is a prerequisite to a valid arbitration award.

In *Burkland v. Johnson*, 50 Neb. 858, 70 N.W. 388 (1897), the Supreme Court of Nebraska held that it is the duty of the arbitrators to make and state separately findings of fact and conclusions of law. And so it could be inferred that they must also conduct their hearings in accordance with evidentiary rules.

Finally, in reviewing arbitration awards courts are authorized by Section 25-1115 to reject an award for any "legal and sufficient reason". As the failure to conduct a trial in accordance with evidentiary rules has been held a legally sufficient reason for reversing a trial court's decision, it would appear that arbitrators' failure to conduct hearings pursuant to rules of evidence might also be a "legal and sufficient reason" for vacating an award.

d) Like referees, arbitrators must state separately their findings of fact and conclusions of law. Sections 25-2108, 25-1131. This would appear to involve a rudimentary record, but not a transcript. However, it should be noted that referees, and therefore arbitrators, unless the parties otherwise provide, must conduct their tribunals "in the same manner as a trial by the court." Literally construing this statutory language in view of the fact that courts keep transcripts, it would appear that arbitrators might have to keep a transcript. On the other hand, no case indicates that a transcript is ordinarily kept or that the failure to keep a transcript is a ground for vacating an award.

e) The Nebraska arbitration statute and case law are silent as to whether the parties may bring a reporter to the arbitration proceedings. As indicated in Question IV (d), it appears that a rudimentary record and perhaps even a transcript of arbitration proceedings are kept. Therefore, it would appear that the purpose of bringing a reporter would be at least partially satisfied. Of course, in any event it would appear that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present at the hearings.

f) Until an arbitration award is confirmed, filed and entered on the court's record, it is without effect. However, once it is confirmed the award has "the same force and effect as the verdict of a jury" and "Judgment may be entered and execution issued accordingly." Section 25-2116.

g) Unlike Sections 12 and 13 which set forth grounds for judicial review, the Nebraska arbitration statute broadly stated the grounds for judicial review. Section 25-2115 provides that "the award may be rejected by the court for any legal and sufficient reason . . . . "

While the grounds for rejecting an award are broadly stated, the Nebraska courts have stated that all presumptions are in favor of sustaining an award. See, *e.g.*, *Johnson v. Johnson*, 87 Neb. 375, 127 N.W. 133 (1910). Under this broad mandate, the courts have said that an award can be set aside for a mistake in computation by all the arbitrators, *Burkland v. Johnson*, 50 Neb. 858, 70 N.W. 388 (1897), or where an award is obtained by fraud, *Morehead v. Adams*, 18 Neb. 569, 26 N.W. 242 (1888). The limits of the scope of "legal and sufficient reason" for rejecting an arbitration award, however, have not been defined by the Nebraska courts.

h) Section 25-2115 authorizes the courts in their discretion to recommit for a rehearing the subject matter of an arbitration controversy to the same or newly chosen arbitrators agreed upon the parties. While the Nebraska courts scrutinize the findings of fact and conclusions of law, it does not appear that the review of the award is tantamount to a de novo proceeding. Support for this conclusion can be garnered from the rules prescribed for the review of referees' reports which are made applicable to arbitrators' awards by Section 25-2108.

Referees' reports are reviewed in the same manner as the decisions of a trial court. Reviews of trial court holdings are not subject to de novo proceedings by appellate courts. Therefore, it would appear that, like court holdings and referees' reports, arbitration awards are not subject to a de novo review.

i) The Nebraska arbitration statute is unusual, aside from those attributes described in analysis of Question IV (a)–(h), *supra,* in that it requires the acknowledgement of an agreement to arbitrate by the parties before a justice of the peace. Section 25-2105. Failure to acknowledge the agreement before a justice of the peace deprives the court of jurisdiction to confirm the award. *Burkland v. Johnson*, 50 Neb. 858, 70 N.W. 388 (1897).

j) No provision of the statute precludes its application to the resolution of personal injury claims. Section 25-2103 provides "All controversies which might be the subject of civil actions" can be submitted to arbitration.

k) Although it would seem that personal injury claims could be settled by arbitration under the statute, there have been no reported appellate court cases where such claims have been resolved pursuant to the statutes' provisions.

l) The Nebraska arbitration statute contemplates the resolution of existing disputes by arbitration. Sections 25-2103, 25-2104, 25-2106. The only future controversies which the parties may agree to settle by arbitration are those arising out of a contract with the Nebraska Department of Roads. All other contracts containing provision requiring the submission of disputes arising out of the contracts are unenforceable.

In *Schrandt v. Young,* 62 Neb. 254, 86 N.W. 1085, 1090 (1901), the Supreme Court of Nebraska, in reviewing the validity of a contract requiring arbitration, held as follows:

> . . . (I)t is well settled in this State that a provision in a contract requiring arbitration, whether of all disputes arising under the contract, or only of the amount of loss or damage sustained by the parties thereto, will not be enforced, and that refusal to arbitrate is not available to the parties in an action growing out of the Contract . . . .

And, in *Phoenix Ins. Co. v. Zlotky,* 66 Neb. 584, 92 N.W. 736 (1902), the Court cited *Schrandt* in rejecting a claim that a contract to arbitrate only the amount of damages could be enforced. The Court, in speaking of the State Constitutional guarantee of trial by jury, held that the right to a jury trial must be preserved inviolate and could not be contracted away.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Since "All controversies which might be the subject of civil actions" may be submitted to arbitration, it would appear that as a matter of Nebraska law existing medical malpractice claims could be resolved by arbitration. On the other hand, it should be recognized that arbitration is apparently not a favored method of resolving controversies. For example, unlike the courts of those states which have enacted the UAA, there is a conspicuous absence of statements by the Nebraska courts asserting that it is the State's public policy to encourage the resolution of disputes by arbitration. Furthermore, notwithstanding the statute's long history of arbitration regulation, there is only a small pool of cases construing its provision. The absence of case law suggests that the statute has enjoyed a limited utility. Moreover, since there is a lack of case law, the meaning and scope of the statute's provisions are still to be resolved. These elements of uncertainty and indefiniteness may, as a practical matter, impede the resort to arbitration to resolve medical malpractice disputes. Finally, and most importantly, the Act's inapplicability to agreements to arbitrate future disputes arising out of a contract might significantly impede its use in the resolution of medical malpractice claims.

NEVADA

I. STATUTORY FOUNDATION

Nevada has enacted an arbitration statute. *Nev. Rev. Stat.* Sections 38.015–38.205 (1969) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

In 1969, the Nevada Legislature enacted its own Uniform Arbitration Act, modeled after and substantially identical to the UAA. It differs from the UAA in the following respects: (1) The Act adds Section 38.025 which defines "Agreement", "Controversy", "Court", "Neutral arbitrator", "Party to the arbitration" and "Written agreement"; (2) the Act adds to the second sentence of Section 38.085, "Representation by attorney", a clause not included in its UAA Section 6 counterpart. The augmented sentence provides that a waiver of representation by a party to arbitration is ineffective "but if one party appears without an attorney in reliance upon such waiver by the opposing party, the arbitrators may grant a continuance to prevent prejudice to the party so relying"; and (3) the Act omits UAA Section 21 (Uniformity of interpretation) and Section 22 (Constitutionality).

III. COMMON LAW ARBITRATION

Although there have been no reported appellate cases recognizing the validity of common law arbitration in Nevada, since the promulgation of the Act, the absence of any provision in the Act negating the right to resolve disputes by common law methods suggests that common-law arbitration is still valid in Nevada.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 38.095(1) empowers arbitrators to issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 38.095(1) empowers arbitrators to administer oaths but does not require that arbitrators administer oaths before taking testimony.

c) Section 38.075(2) states that "The parties are entitled to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing." Beyond these safeguards, the Act is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

d) Although Section 38.105(1) requires that "The award shall be in writing and signed by arbitrators joining in the award," the Act is silent as to whether a transcript of the arbitration proceeding must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act and case law are silent as to whether the parties may bring a reporter to the arbitration proceedings. However, it would appear that the parties could agree to submit to arbitration on the condition that a reporter be present at the proceedings or even that a transcript of the proceedings be kept.

f) Except where the grounds for opposing an arbitration award exist under Sections 38.145 and 38.155 or where the court declines to confirm an award on grounds other than those stated in Section 38.145(1) (e) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

g) Grounds for judicial review are substantially identical to those of the UAA. More specifically, Section 38.145 (Vacating award) and Section 38.155 (Modification or correction of award) set forth grounds for judicial review.

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Rather, where an award is rendered in compliance with all the Act's requirements, it is a final and binding determination of the issue submitted and precludes a de novo determination of that issue by a court or by a subsequent arbitration. *Northwestern Security Ins. Co. v. Clark*, 84 Nev. 716, 448 P.2d (1968).

i) There are no peculiarities in the Act.

j) No provision of the Act precludes its application to the settlement of personal injury claims.

k) Personal injury claims have been resolved under the Act. In *Northwestern Security Ins. Co. v. Clark*, 84 Nev. 716, 448 P.2d 39 (1968), two automobile insurance companies providing uninsured motorist coverage with respect to a passenger who was killed in an auto collision submitted to arbitration the issue of whether either policy applied and what liability for damages each owed the deceased passenger's estate.

l) Section 38.035 expressly recognizes the validity of agreements to settle existing and future disputes by arbitration. In pertinent part, it states: "All written agreement to submit any existing controversy to arbitration or a provision in a contract to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract."

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given the resolution of personal injury claims under Nebraska's Act, it would appear that medical malpractice disputes could be resolved under the Act. Additionally, the broad language of Section 30.035 which authorizes written submissions of "any controversy" to arbitration suggests that medical malpractice claims could be resolved under the Act.

NEW HAMPSHIRE

I. STATUTORY FOUNDATION

New Hampshire has enacted an arbitration statute. *N.H. Rev. Stat. Ann.* Sections 542:1 to 542:10 (1955).

II. RELATIONSHIP OF STATUTE TO UAA

Although the New Hampshire arbitration statute, which was first enacted in 1929, is not modeled after the UAA, it is similar to the UAA in several material respects. Like the UAA, the New Hampshire statute is applicable to written agreements to submit existing disputes to arbitration as well as contracts to arbitrate disputes arising out of those contracts. Moreover, the New Hampshire courts are authorized to compel arbitration, and procedures for confirming, vacating and modifying an award are set forth in the New Hampshire arbitration statute.

There also are a number of differences between the New Hampshire arbitration statute and the UAA. There is no statutory language in the New Hampshire act guaranteeing parties to arbitration the right to representation by counsel. Moreover, the statute is generally less comprehensive than the UAA with regard to the procedural mechanics of conducting hearings. Further dissimilarities between the New Hampshire statute and the UAA are set forth in the analysis of the "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

Although there are no reported appellate court cases involving common law arbitration after the statutory enactment, the absence of any provision negating its validity suggests the Act is not in derogation of the common law. *See Truesdale v. Straw*, 58 N.H. 207 (1877).

IV. PROCEDURAL

a) Section 542:5 states, in part, that "Any person may be summoned as provided in chapter 516, RSA, to attend before the arbitrators as a witness . . . If any person . . . so summoned to testify shall refuse or neglect to attend, upon petition the court in and for the county in which such arbitrators are sitting may compel the attendance of such person. . . before said. . . arbitrators or punish said person. . . for contempt in the same manner now provided in chapter 516."

Chapter 516 empowers any justice to issue subpoenas for the attendance of witnesses before arbitrators. Chapter 516:3, in pertinent part, states: "Any justice may issue such writs for witnesses . . . before auditors, referees, arbitrators or commissioners."

b) The New Hampshire arbitration statute is silent as to whether the arbitrators are empowered to administer oaths and as to whether oaths must be administered before evidence may be heard by the arbitrators.

c) The New Hampshire arbitration statute is silent as to whether arbitration proceedings must be conducted in accordance with strict evidentiary rules. Furthermore, unlike UAA Section 5 which states that "The parties shall have the right to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing," the New Hampshire statute does not expressly safeguard these rights.

d) Although Section 542:7 requires that "The award must be in writing and . . . signed by the arbitrators or by a majority of those sitting," the statute is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The statute and case law are silent as to whether the parties may agree to bring a reporter to the arbitration proceedings. It would appear, however, that the parties could condition their agreement to arbitrate on the presence of a reporter at the proceedings, or the making of a transcript of the proceedings.

f) Although the New Hampshire statute sets forth a procedure whereby a party to the arbitration may apply to the superior court within one year after an award is made for an order confirming an award, the statute is silent as to the force and effect of such confirmation and judgment.

It would appear that the statutory purpose of this procedure is to render an award final and binding.

g) Grounds for judicial review are similar to those of the UAA. Section 542:8 sets forth six grounds on which a party may apply to the superior court for an order modifying or vacating an order. In pertinent part, it states:

> At any time within one year after the award is made any party to the arbitration may apply to the superior court for an order . . . correcting or modifying the award for plain mistake, or vacating the award for fraud, corruption or misconduct by the parties or by the arbitrators, or on the ground that the arbitrators have exceeded their powers.

h) The statute does not provide for a trial de novo of the subject matter of the arbitration.

In *Southwestern New Hampshire Transp. Co. v. Durham*, 102 N.H. 169, 152 A.2d 596 (1959), the Supreme Court of New Hampshire pointed out in a case involving an employee's grievance with his employer that issues of fact which were or could have been raised before the arbitrators are not retriable by the court except where the arbitrators have made a plain mistake or exceeded their powers.

i) The statute is peculiar in that it is expressly inapplicable to arbitration agreements between employers and employees or between employers and associations of employees unless such agreement specifically provides that it is governed by the statute's provisions.

j) No provision of the statute precludes its application to the resolution of personal injury claims.

k) Given the absence of any provision prohibiting the resolution of personal injury claims, and the language of section 542:1 which states that parties may submit "any controversy" to arbitration, it would appear that personal injury claims could be resolved by arbitration under the statute. There appear to be no reported appellate court cases indicating that the statute has been used to resolve personal injury claims. However, in *Korouac v. Healy*, 104 N.H. 157, 181 A.2d 63 (1962), the court specifically upheld arbitration of uninsured motorist coverage disputes.

l) Section 542:1 provides that a contract to submit existing as well as future controversies to arbitration "shall be valid, irrevocable and enforceable, save upon grounds as exist at law or in equity for the revocation of any contract."

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there appear to be no reported appellate court cases in which the statute has been used to resolve personal injury claims, it nevertheless appears that the statute could be used to resolve medical malpractice disputes. Support for this tentative conclusion can be garnered from the language of Section 542:1, which states that "An agreement in writing to submit to arbitration *any controversy* existing at the time of the agreement to submit" is valid. [Emphasis added]. This broad authorization would appear to encompass agreements to arbitrate existing medical malpractice claims, and it would appear that such claims could also be arbitrated where they arise out of contracts containing a provision to arbitrate.

NEW JERSEY

I. STATUTORY FOUNDATION

New Jersey has enacted an arbitration statute, *N.J. Stat.* 2A: 24-1 to 2A: 24-11 (1952) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

Dissimilarities:

A. Proceedings to compel or stay arbitration: Act Section 2A: 24-1, 3, 4—UAA Section 2.

Both statutes provide for court proceedings to compel or stay arbitration. However, under the Act, the party alleged to be in default may demand a jury trial on the issue of the validity or non-existence of an agreement to arbitrate, whereas there is no such provision in UAA. But, under the Act, there is no provision for severability of issues subject to arbitration as there is in the UAA.

B. Appointment of Arbitrators by the Court: Act Section 2A: 24-5—UAA Section.

The major dissimilarity between the statutes with regard to the appointment of arbitrators is that only one arbitrator shall be appointed in New Jersey unless otherwise provided, whereas the UAA provides for appointment of one or more arbitrators.

C. Hearing: Act Section 2A: 24-6-UAA Sections 5, 6, 7.

Unlike the UAA, the New Jersey statute does not require that arbitrators when appointing a time and place for a hearing to cause notification to be served on the parties five days before the hearing. Nor does the Act equip the arbitrators with the discretionary power to postpone or adjourn the arbitration hearing on their own motion.

D. Award: Act Section 2A: 24-7-UAA Sections 8, 11.

The major difference between the statutes is that the award will be confirmed if exception is not taken within 20 days under the UAA, whereas the parties have a 3-month period in New Jersey during which they may object for the purposes of changing an award.

E. Vacating an Award: Act Section 24-8-UAA Section 12.

The two statutes' provisions are essentially the same with regard to vacating an award except that under the UAA the parties may move to have the award vacated 10 days after the grounds for vacating are known or should have been known to the parties, whereas under the New Jersey Act, the parties are barred from bringing an action to have the award vacated if 3 months have expired from the time the arbitration award has been presented.

F. Modification or Correction of Award: Act Section 24-9-UAA Section 13.

There is no substantial difference between the statutes with regard to modification or correction of awards except that the UAA provides that a motion to modify or correct an award may be joined in the alternative with an application to vacate it.

G. Judgment or Decree on Award: Act Section 24-10—UAA Section 14.

There is no substantial difference between the two statutes on this point.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the New Jersey Courts have continued to recognize the validity of common-law arbitration. *Carpenter v. Bloomer*, 54 N.J. Super., 148A.2d 497 (1959); See generally Note, *Labor Arbitration in New Jersey*, 14 Rutgers L. Rev. 143, 145-151 (1959).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 24-6 authorizes the arbitrator to subpoena witnesses and documents.

b) The Act does not specifically require that the testimony of witnesses at the arbitration proceedings be made under oath.

c) The Act does not require that strict evidentiary rules be adhered to in arbitration proceedings. However, the New Jersey courts have held that arbitration proceedings are to be conducted in accordance with "ordinary principles upon which other inquiries are conducted."

d) The Act does not require that a transcript be kept, and a review of the case law does not indicate that the New Jersey courts have judicially required the arbitrators to make a transcript or furnish the parties with a transcript.

e) The statutory language of the Act neither prohibits nor permits the parties to bring reporters to their arbitration proceedings. Just as the Act is silent as to the permissibility of reporters at the arbitration proceedings so is the case law construing the Act.

f) Although Sections 2A: 24-7 to 24-9 provide for judicial review in a manner substantially identical to that of the UAA, in the absence of misconduct or want of good faith of the arbitrators, an arbitration award is usually unassailable and operates as a final and binding determination on the parties. *Daly v. Komline-Sanderson Eng. Corp.*, 40 N.J. 175, 191A.2d 37 (1963); *International Ass'n. of Machinists, Lodge 1292, Ind. v. Bergen Ave. Bus Owners Ass'n.*, 3 N.J. Super. 558, 64 A.2d 362 (1949); *Rosa v. Transport Operators Co.*, 45 N.J. Super. 133 A.2d 24 (1957).

g) Grounds for judicial review are substantially identical to those of UAA and are set forth in Section 2A: 24-8.

h) Section 2A: 24-8(d) provides that if the arbitration award is set aside, the court may, in its discretion, direct a rehearing by the arbitrators, or the parties may be relegated to their original remedies and an action will lie on the underlying demand. *Held v. Comfort Bus Line*, 136 N.J. L. 640, 57 A.2d 20 (1948).

i) No provision in the Act prohibits arbitration of personal injury claims.

j) There are no reported appellate court cases where the Act has been used to settle personal injury claims.

k) Sections 2A: 24-1, 24-2 explicitly provide that arbitration may be applied to existing controversies as well as prospective controversies.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although no appellate court cases were uncovered where the New Jersey Arbitration Act has been used to settle a personal injury claim, no statutory or judicial language suggested that the use of the Act for the resolution of medical malpractice claims would be barred. And the great number of cases which have been arbitrated involving a variety of subject matters under the Act, and the court's frequent pronouncements that arbitration is favored at law suggest that medical malpractice disputes could be arbitrated under the Act.

NEW MEXICO

I. STATUTORY FOUNDATION

New Mexico has recently enacted an arbitration statute. *N.M. Stat. Ann.* Sections 22-3-9 to 22-3-31 (Supp. 1971). (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The New Mexico Uniform Arbitration Act is substantially identical to the UAA.

III. COMMON LAW ARBITRATION

Referring to a superseded arbitration statute, the New Mexico Supreme Court held that both common law and statutory arbitration may exist without conflict in the State. *Robinson v. Navajo Freight Lines, Inc.* 70 N.M. 215, 372 P.2d801 (1962). Given the Court's past construction that statutory arbitration is supplementary to the common law, it is likely that the New Mexico courts would continue to recognize the validity of common law arbitration.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

(a) Section 22-3-15 empowers arbitrators to issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

(b) Section 22-3-15 empowers arbitrators to administer oaths but does not require that oaths be administered before taking evidence.

(c) The Act does not indicate whether in the conduct of arbitration proceedings, rules are to be observed. However, Section 22-3-13(b) entitles parties to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing.

(d) Although Section 22-3-16(a) states that "The award shall be in writing and signed by the arbitrators joining in the award", the Act is silent as to whether a transcript of the proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

(e) The Act does not prohibit an agreement between the parties to have a reporter at the arbitration proceedings. The case law gives no indication as to whether parties may agree to bring a reporter to the arbitration proceedings.

(f) Except where the grounds for opposing an arbitration award exist under Section 22-3-20 or where the court declines to confirm an award on grounds other than those stated in Section 22-3-20(a) (5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

(g) Grounds for judicial review of arbitration awards are substantially identical to those of the UAA. More specifically, Section 22-3-20 (Vacating an award) and Section 22-3-21 (Modification or correction of award) set forth grounds for judicial review of arbitration awards.

(h) There is no trial de novo of the subject matter of a validly arbitrated dispute. Section 22-3-20(c) states that the court in vacating an award on grounds other than those stated in Section 22-3-20(a) (5) "may order a rehearing before new arbitrators. . . ."

(i) There are no peculiarities in the Act.

(j) No provision of the Act prohibits agreements to arbitrate personal injury claims.

(k) There are no reported appellate court cases where the Act has been used to settle personal injury claims.

(l) Section 22-3-9 provides that a written agreement to submit any existing controversy to arbitration or a provision in a written contract to submit to arbitration any controversy thereafter arising between the parties is valid.

Prior to New Mexico's enactment of the UAA, a contract provision stipulating that all future disputes arising between the parties would be settled by arbitration was held void as against public policy. *State ex rel. Duke City Lumber Co. v. Wood,* 81 N.M. 285, 466 P.2d 562 (1970).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

While the Act has not spawned appellate case law indicating its application to the settlement of personal injury claims, there is no provision in the Act which would appear to impair its use for the settlement of medical malpractice claims.

New Mexico's enactment of Section 22-3-29 which states that the Act "shall be so construed as to effectuate its general purpose to make uniform the law of those states which enact it," suggests that medical malpractice disputes could be arbitrated under the Act in the same manner as these disputes have been resolved in other uniform arbitration act jurisdictions. *See* Arizona, *supra.*

NEW YORK

I. STATUTORY FOUNDATION

New York has enacted an arbitration statute, N.Y. CPLR Sections 7501 - 7514 (McKinney 1963).

II. RELATIONSHIP OF STATUTE TO UAA

The New York statute is similar to the UAA. However, there are several relatively minor differences between the Acts.

The New York Statute provides for a slightly different order of places for venue than does UAA Section 18. N.Y. Section 7502 gives priority to the court of the county in which one of the parties resides or is doing business while

UAA Section 18 would prefer the county where the arbitration was held.

Unlike the UAA, which is not affected by a statute of limitations, Section 7502(b) is substantially identical to UAA Section 2(a)-(d). But Section 7503(b) provides that a person who has not participated in the arbitration proceeding and who has not made or been served with an application to compel arbitration may apply to stay arbitration on the ground that the claim sought to be arbitrated is barred by the Statute of Limitations.

Under Section 7503(c), notice of intention to arbitrate may be served by one party to another specifying the agreement pursuant to which arbitration is sought. Having received notice to arbitrate, the party served must apply to stay arbitration within ten days after service upon him of the notice to arbitrate. Failure to apply to stay arbitration in due time bars the party served who later objects to arbitration on the grounds (1) that a valid agreement to arbitrate had not been made, or (2) that the agreement to arbitrate had not been complied with. In contrast, the UAA does not have any provision acting as a statute of limitations which would bar a party from raising either of the aforementioned objections.

Section 7504, providing for court appointment of arbitrators, is substantially identical to UAA Section 3. New York empowers arbitrators to issue subpoenas and administer oaths as does the UAA Section 7 (a).

Unlike the UAA, New York requires arbitrators to take an oath before carrying out their duties, Section 7506(a). Section 7506(b) provides that the parties to an arbitration proceeding must receive 8 days notice of the time and place of the hearing; the UAA Section 5(a) provides for only 5 days notice.

Section 7506(c) (Hearing-Evidence) has provisions identical to those found in Section 5(a) and Section 5(b) of the UAA. The right of attorney provided for in Section 7506(d) parallels UAA Section 6, except that the UAA may allow a party to waive his right to an attorney at the beginning of a proceeding and thus be unable to assert the right to attorney later in the proceedings. On the other hand, Section 5606(d) provides that the right to attorney may be asserted as to any part of the arbitration or hearings which have not taken place and that this right may not be waived.

Section 7506(f) provides that except for the right to attorney, the parties can waive any of the requirements of Section 7506 if they give their consent in writing or continue with the arbitration without objection. Thus, the parties could waive their rights to be heard, to present evidence and cross-examine witnesses, the eight day notice requirement of the time and place for the hearing, or the requirement that all the arbitrators conduct the hearing. The UAA, however, does not provide for such a waiver.

With the exception that Section 7507 requires that the arbitration award be acknowledged by the arbitrator, it is virtually identical to UAA Section 8.

Section 7508 provides for awards by confession for money due or to become due at any time before an award is otherwise made if the parties so choose. This section can be used to save time where there is an agreement as to some liability but a disagreement as to amount. In contrast, the UAA has no formal provision for such an action.

Except for the provisions for different time limits, Section 7509 relating to application for modification of award, closely approximates UAA Section 9. Similarly, Section 7510 dealing with confirmation of awards is almost identical to UAA Section 11, except that the New York Statute expressly provides for exactly a year's time within which to bring the request, while the UAA is less specific.

Section 7511, dealing with grounds for vacating or modifying an award, is substantially the equivalent of UAA Section 12 and Section 13.

Unlike the UAA, the New York Statute has a provision to take effect upon death or incompetency of a party where that party has agreed to submit a controversy to arbitration and the proceedings are to begin or are being conducted. Section 7512 makes clear the course the proceedings are to follow if a party becomes incompetent or dies. Moreover, Section 7512 allows the court to extend the time within which an application to confirm, vacate or modify the award, or to stay arbitration must be made where a party to an arbitration agreement becomes incompetent or dies.

Both Section 7513 and UAA Section 10 provide that unless the parties have agreed otherwise the fees and expenses of arbitration, not including attorney's fees, shall be paid as provided in the award. However, the New York Statute allows the courts, on application by a party, to reduce or disallow any fee or expense it finds excessive or to allocate it as justice requires.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

(a) Section 7505 states that "An arbitrator and any attorney of record in the arbitration proceeding has the power to issue subpoenas." An arbitrator can compel even one not a party to the agreement to produce books and records if such documents are shown to be material, pertinent or necessary to any matter lawfully under consideration by him. *Re-Anne Mfg. Co.*, 1 Misc. 2d 717, 149 N.Y.S. 2d 161 (1955).

(b) There is no statutory provision requiring that witnesses be sworn. "[T]he arbitrator is bound by the rules of evidence and may rely upon unsworn hearsay; (thus) he is under no obligation to insist on the witness' being sworn." *Kozlowski v. Seville Syndicate, Inc.*, 64 Misc. 2d 109, 114-115, 314 N.Y.S. 2d 439, 446 (1970). However, by Section 7505, the arbitrator does have the power to administer oaths.

(c) According to Section 7506, the parties to an arbitration proceeding are entitled to be heard, to present evidence and to cross-examine witnesses. These rights can be waived by the parties and are treated as waived if the parties continue in the arbitration without objecting to the denial of their rights. Section 7506(f).

The courts have ruled that arbitrators are not limited in the discharge of their duty by the rules of evidence or by the body of use and statutory law governing the prosecution of actions. Nor are arbitrators restricted to consideration of any such evidence as the parties see fit to produce, unless the terms of the submission so provide. *Korein v. Rabin*, 29 A.D. 2d 895, 287 N.Y.S. 2d 970, 980 (1968), *accord Kozlowski, supra*, 64 Misc. 2d 109, 314 N.Y.S. 2d 439.

(d) The statute is silent as to whether a transcript of the arbitration proceeding need be kept. The courts have held that no record need be kept in an arbitration proceeding. *Aimcee Wholesale Corp. v. Tomar Products, Inc.*, 289 N.Y.S. 2d 968, 21 N.Y. 2d 621, 237 N.E. 2d 223 (1968).

(e) The statute and cases are silent as to whether the parties may bring a reporter. It would appear, however, that they could provide as a condition of their agreement to arbitrate that a reporter be present at the proceedings or that a transcript be kept.

(f) In *Fundicker v. Guardian Mut. Life Ins. Co.*, 62 N.Y. 392, 399-400 (1875), the New York Court of Appeals said:

> The parties by their agreement to arbitrate have invested the arbitrator with judicial functions in a particular case; all questions of fact or law are submitted to him for final decision; and the courts do not review arbitrators decisions de novo in the merits.

The award need not be confirmed by the courts to make it enforceable. *Rubman v. Lewin*, 196 Misc. 189, 89 N.Y.S.2d 203 (1949). The effect of an award is to serve as a complete bar to the maintenance of any action upon the original right or cause. In short, the award is substituted for the original cause. *New York Lumber and Wood Working Co. v. Schneider*, 119 N.Y. 475, 24 N.E. 4 (1890).

(g) An award may not be vacated or modified for grounds other than those provided by Section 7511. *Barbuto v. Motor Vehicle Accident Indem. Corp.*, 29 A.D.2d 927, 289 N.Y.S.2d 118 (1968); *accord*, *Lentine v. Fundaro*, 36 A.D.2d 539, 318 N.Y.S.2d 564 (1971).

An award may not be set aside by the court merely because the award is against the weight of the evidence. To set aside an award the determination must be so divorced from rationality that it can be accounted for only by one of the kinds of misbehavior cited in the statute. *Isbrandtsen Tankers v. National Marine Eng'rs. Beneficial Ass'n.*, 236 N.Y.S. 2d 808 (1962).

Arbitrators are not required to set forth the reasoning underlying their award. *Aimcee Wholesale Corp. supra*, 289 N.Y.S. 2d 968, 21 N.Y. 2d 621, 237 N.E. 2d 223 (1968). Nor are arbitrators required to set forth in specific detail the particular issues of findings which they decided unless the parties so require by the terms of the submission. *Colletti v. Mesh*, 23 A.D. 2d 245, 260 N.Y.S. 2d 130, *aff'd* 266 N.Y.S. 2d 814, 17 N.Y. 2d 460, 213 N.E. 2d 894 (1965).

Absent a showing of misconduct on the part of the arbitrators, the court is not entitled to inquire into the reasoning or processes by which the arbitrators arrived at the award. *Cinebox Gen. Advertising, Inc. v. Societa Internazionale Fonovisione*, 29 A.D. 2d 534, 285 N.Y.S. 2d 873, *motion denied*, 289 N.Y.S. 2d 628, 21 N.Y. 2d 912, 236 N.E. 2d 860, *aff'd* 291 N.Y.S. 2d 815, 22 N.Y. 2d 705, 238 N.E. 2d 922 (1968).

The court may not sutstitute its judgment for that of the arbitrator merely because it disagrees with an award. *Barbuto, supra*, 29 A.D. 2d 927. The arbitrators' award, as rendered, may not be vacated for errors of law or fact. *Lentine v. Fundaro, supra*, 36 A.D. 2d 539, 381 N.Y.S. 2d 564 (1971).

CPLR Section 7511 (b) (1) sets forth the grounds on which an award may be vacated or modified. On application by a party who had notice of the hearing the court may vacate an award if it finds that the rights of that party were prejudiced:

1) by corruption, fraud or misconduct in procuring the award; or
2) by partiality of an arbitrator appointed as a neutral; or
3) because an arbitrator, or agency, or person making the award exceeded his power or so imperfectly executed it that a final and definite award upon the subject matter submitted was not made; or
4) because there was a failure to follow the procedure set out by the arbitration statute.

A party who neither participated in the arbitration proceeding nor had notice of the arbitration may have the award set aside under Section 7511 (b) (2) for any of the grounds specified in Section 7511 (b) (1), or if a valid agreement to arbitrate was not made, or if the agreement to arbitrate was not complied with, or if the arbitrated claim was barred by the Statute of Limitations under Section 7502(b).

According to Section 7511(c) the court shall modify the award if there was a miscalculation of figures or a mistake in the description of any person, thing or property referred to in the award; or if the arbitrators have awarded upon a matter not submitted to them and the award may be corrected without affecting the merits of the decision upon the issues submitted; or if the award is imperfect in a matter of form, not affecting the merits of the controversy.

(h) "The parties by their agreement to arbitrate have invested the arbitrator with judicial fnnctions in a particular case; all questions of fact or law are submitted to him for final decision; and the courts do not review arbitrators' decisions de novo on the merits. *Fundicker v. Guardian Mutual Life Ins. Co.*, 62 N.Y. 392, 399-400. . . . ", *Wagner v. Russek's Fifth Avenue, Inc.*, 281 A.D. 825, 826, 119 N.Y.S.2d 269, 270 (1953).

However, the question of the scope of the submission is one of law to be decided by the Court. *Graphite Metalizing Corp.*, 271 A.D. 839, 66 N.Y.S.2d 53 (1946).

(j) No provision in the statute disallows its use to settle personal injury claims.

(k) While it would appear that the statute could be used to settle personal injury claims, there have been no reported appellate court cases where New York's arbitration statute has been used to settle a personal injury claim.

(l) Section 7501 expressly provides for the arbitration of an existing controversy or a future controversy where the parties have entered into a written agreement to submit such controversies to arbitration.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although the New York Statute has not spawned any appellate case law where it has been used to settle personal injury claims, since it is similar to the UAA, it would seem that the statute could be used to settle medical malpractice claims.

NORTH CAROLINA

I. STATUTORY FOUNDATION

North Carolina has enacted an arbitration statute. *N.C. Gen. Stat. Ann.* Sections 1-544 to 1-567 (Repl. Vol. 1969).

II. RELATIONSHIP OF STATUTE TO UAA

The North Carolina statute, enacted in 1927 was modeled after an earlier Uniform Act formulation. It differs from the present UAA in many respects and its procedural mechanism and scope of application are far less comprehensive than the UAA.

While the UAA empowers arbitrators to determine issues of law and fact and recognizes the arbitrators' decision as final and binding on the parties, the North Carolina Act establishes a procedure whereby parties to the arbitration may request that arbitrators submit questions of law arising in the hearing to the court and the court's determination of that issue is binding on the arbitrators. Section 1-556(1). Moreover, Section 1-556(2) of the North Carolina Act requires arbitrators to state their final award in the form of a conclusion of fact so that the court may scrutinize the arbitrators' determination of questions of law. In contrast to this requirement, the UAA Section 8(a) only requires that the award be made in writing and signed by the arbitrators joining in the award.

The North Carolina Act, Sections 1544 and 1545, is unlike the UAA Section 1 in that it is not explicitly applicable to written agreements to submit existing controversies to arbitration.

Unlike UAA Section 2 which, upon application of a party showing an agreement to arbitrate, authorizes the Court to order the parties to proceed with arbitration, the North Carolina Act offers no similar procedural mechanism. Rather, under the North Carolina Act, either party may breach his contract to submit to arbitration any time before an award is rendered and seek a remedy in the courts. *McDonough Constr. Co. v. Hanner*, 232 F. Supp. 887 (M.D. N.C. 1964).

The North Carolina Act limits the time within which an award may be made by the arbitrators. Although the UAA does not set a specific time limit for the rendering of an award where the parties have omitted a time limit, the North Carolina Act treats any award made after sixty days from the time of the appointment of the arbitrators as a nullity. Section 1-551.

Further procedural dissimilarities are indicated in the analysis of "Procedural Attributes of the Statutes". (Question IV).

III. COMMON LAW ARBITRATION

The North Carolina courts have construed the enactment of the State's statutory arbitration scheme as constituting an enlargement on the common law rule, and provisions of the arbitration statute have been held to be cumulative and concurrent rather than exclusive. *Thomasville Chair Co. v. United Furniture Workers*, 233 N.C. 46, 62 S.E. 2d 535 (1950). Consequently, where the method of arbitration adopted by the parties is not in conformance with the arbitration statute but complies with the procedure of submitting disputes to arbitration at common law, the courts have upheld agreements to arbitrate and awards made under common law arbitration. *Brown v. Moore*, 229 N.C. 406, 50 S.E. 2d 5 (1948).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

(a) Section 1-553 empowers arbitrators to issue subpoenas for any person to appear before them as a witness and to bring with him any book, writing or other evidence.

(b) The North Carolina act does not empower arbitrators to administer oaths, and it would appear that testimony given at arbitration hearings is not under oath. However, it should be noted that Section 1-544 provides that "Depositions may be taken . . . in the same manner . . . as provided by law for the taking of deposition in suits pending in the courts of record in his State."

(c) The North Carolina act and case law are silent as to whether strict evidentiary rules are observed in the conduct of arbitration proceedings.

(d) Although Section 1-557 requires that "The award of the arbitrators . . . shall be drawn up in writing and signed by the arbitrators. . .", The North Carolina act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this question suggest that the parties need not and do not as a matter of practice keep a record.

In addition to the silence of the act and case law as to whether a transcript of the arbitration proceedings must be kept, Section 1-563 supports the conclusion that a transcript need not be kept. Section 1-563 lists the papers to be filed by a party moving for an order confirming, modifying, correcting or vacating an award. However, it does not require the filing of a transcript, and, in fact, is silent as to the existence of a transcript.

(e) The North Carolina Act is silent as to whether reporters may be brought to the arbitration proceeding. It would appear, however, that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present or even that the arbitrators keep a transcript of the proceeding.

(f) An award is final and binding on the parties where the award rendered conforms to the requirements of the submission and is reached without fraud, partiality or such manifest mistake as naturally works a fraud.

(g) Grounds for judicial review are similar to those of the present UAA. More specifically, Section 1-559 (Order vacating award) and Section 1-560 (Order modifying or correcting award) set forth grounds for judicial review of arbitration awards.

(h) The North Carolina act does not provide for a trial de novo of the subject matter of arbitration awards. Where an award is rendered in compliance with the Act's requirements, it is a final and binding determination of the controversy which may not be disturbed unless statutory grounds exist.

(i) Aside from the peculiarities indicated in the analysis of Question II, there are no other noteworthy peculiarities in the North Carolina act.

(j) No provision in the North Carolina act makes it inapplicable to the settlement of personal injury claims.

(k) Although it would seem that the Act could be used to settle personal injury claims, there have been no reported appellate court cases where the Act has been so used.

(l) Section 1-544 expressly recognizes the validity of written agreements to settle existing disputes by arbitration. In pertinent part, it states: "Two or more parties may agree in writing to submit to arbitration, in conformity with the provisions of this article, any controversy existing between them at the time of the agreement to submit." Moreover, Section 1-545 provides: "The arbitration agreement must state the question or questions in controversy with sufficient definiteness to present one or more issues or questions upon which an award may be based."

While the Act recognizes the validity of agreements to submit existing disputes to arbitration, it appears from the act and the case law that agreements to submit future disputes to arbitration are invalid. However, it also appears from the case law construing Section 10544 that not all disputes which arise out of a contract are void as future disputes ousting the courts of their jurisdiction. Rather, the test of validity is whether the contract to submit a controversy to arbitration purports to oust the court's jurisdiction. *Swaim v. Swaim* 14 N.C. 24 (1831).

In determining whether a particular contract purports to oust the Court's jurisdiction, the North Carolina courts have generally held that an agreement to submit the liabilities and rights of the parties which is to turn on an issue of law is invalid. *Skinner v. Gaither*, 234 N.C. 385, 67 S.E.2d 267 (1951); *McDonough Constr. Co. v. Hanner*, 232 F. Supp. 887 (M.D.N.C. 1964). On the other hand, where the dispute previously agreed to be submitted to arbitration involves the determination of a single fact, such as the amount of loss by fire an insured suffered and not the legal liability of the insurer, the agreement is valid. *Nelson v. Atlantic Coast Line R.R.*, 157 N.C. 194, 72 S.E. 998 (1911).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there have been no reported appellate cases indicating that the Act has been used to settle personal injury claims, it would appear, given the broad language of Section 1-544 stating that parties may agree to submit "any controversy" existing between them to arbitration, that medical malpractice disputes could be resolved under the Act.

NORTH DAKOTA

I. STATUTORY FOUNDATION

North Dakota has enacted an arbitration statute, *N.D. Code Ann.* Section 32-29-10 through 32-29-21 (1960) (Hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

Although the North Dakota statute is not patterned after the UAA, it does have many similar provisions. The differences between the North Dakota Act and the UAA are described in the "Analysis of the Procedural Attributes of the Statute" (Question IV).

III. COMMON LAW ARBITRATION

In *Johnson v. Wineman*, 34 N.D. 116, 157 N.W. 679 (1916), the North Dakota Supreme Court determined that where the arbitration proceedings failed to conform to the statutory requirements the award would be upheld if it was sufficient at common law. In sum, "the statutory and common law proceedings relating to arbitration and award are merely cumulative in the state." *Johnson v. Wineman, supra*, 34 N.D. at 122, 157 N.W. at 681.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) The Act does not clothe arbitrators with the subpoena power. Rather Section 32-29-05 provides that "witnesses may be compelled to appear before such arbitrators by subpoena *to be issued by any County Justice*, in the same manner and with like effect, and subject to the same penalties for disobedience, as in cases of trials before county justices." (Emphasis added).

b) Section 32-29-03 empowers arbitrators to administer oaths to witnesses and to hear allegations and evidence of parties. However, arbitrators are not required to administer oaths to witnesses who testify at the proceedings. On the other hand, Section 32-29-04 requires that "Before acting, the arbitrators must be sworn before an officer authorized to administer oaths faithfully and fairly to hear and examine the allegations and evidence of the parties in relation to the matters in controversy and to make a just award according to their understanding."

c) Both the Act and the case law construing the Act are silent as to whether the rules of evidence are adhered to in arbitration proceedings.

d) The Act does not require that a transcript be kept of the arbitration proceedings. However, Section 32-29-14 provides that when an appeal is taken from a judgment entered upon an arbitration award affidavits and all other papers relating to the arbitration award must be annexed to the record of judgment which is transmitted to the Supreme Court for review.

e) Generally, the award of the arbitrators is final. A motion to affirm the award may be made under Section 32-29-07 within one year of the filing of the award and upon eight days' notice to the adverse party. However, *Maw v. Ketzman*, 55 N.D. 463, 214 N.W. 273 (1927) requires that an arbitration award be complete and final as to all matters submitted to arbitration if it is to be valid and constitute a judgment roll.

In *Maw*, which involved a dissolution of partnership, the arbitrators' award was reached without attempting to determine what constituted the partnership's assets and liabilities and without attempting to determine what indebtedness existed between partners as provided by the agreement to arbitrate. Consequently, the Supreme Court of North Dakota struck down the arbitration award and stated that "there must be such finality as will prevent litigation, present or future" if the arbitration award is to be final and finding on the parties. *Maw v. Ketzman*, *supra*, 55 N.D. at 467, 214 N.W. at 274.

g) Limited grounds for judicial review of arbitration awards are provided by the Act. Like UAA Section 5, the Act's Section 32-29-08 provides that a party may move the Court to vacate an award upon any of the following grounds:

1) That the award was procured by corruption, fraud or other undue means.
2) That there was evident partiality or corruption in one or more of the arbitrators.
3) That the arbitrators' refusal to postpone the hearing or to hear evidence constituted misconduct which prejudiced the complaining party.
4) That the arbitrators exceeded their powers or failed to make an award on the subject matter submitted to arbitration.

Sections 32-29-09 and 32-29-10 list circumstances where the court may vacate or modify an award which are substantially identical to those of UAA Section 13.

h) The Act does not provide for a trial de novo of any arbitrated dispute. Nor have the North Dakota courts considered themselves to have the power to try de novo issues submitted to arbitration. In *Maw*, *supra*, the Court found that an appeal from an award vacating an award does not call for a trial de novo.

Section 32-29-10 authorizes the Court on a motion to vacate the arbitration to order a rehearing by the arbitrators if the time within which such award shall have been required to be made by the agreement to arbitrate has not expired.

i) The statute has several unique features: (1) Section 32-29-10 provides that arbitration cannot be used to determine the question to title of real property in fee for life. (2) Section 32-29-04 provides that the arbitrators must be sworn in before they begin their duties. (3) Section 32-29-20 provides that all costs of arbitration be paid by the party revoking the submission to arbitration prior to the publication of the award. However, the parties cannot revoke the power of the arbitrators after the question has been submitted finally to them for determination. (4) Section 32-29-21 makes provisions similar to Section 32-29-20 where arbitration was the condition of a bond. (5) There is no provision in the North Dakota Statute similar to Section 3 of the UAA which authorizes the court to appoint arbitrators. (6) *N.D. Code Ann.* Section 32-04-12(3) (1960) provides that an obligation to agree to submit a controversy to arbitration cannot be specifically enforced. However, the Supreme Court of North Dakota, in *Modenstrom v. Swedberg*, 143 N.W.2d 848 (1966), determined that it could specifically enforce a mandatory arbitration clause of a contract which was fully performed in Minnesota. It found the issue was substantive and applied, under its conflict of laws rule, the law of Minnesota.

j) There does not appear to be any provision in the Act which would make it inapplicable to personal injury claims.

k) There have been no reported appellate court cases where the Act has been used to settle personal injury claims.

l) Section 32-29-01 provides that "Persons capable of contracting may submit to the decision of [arbitrators] any controversy which might be the subject of a civil action between them . . . ." This section contemplates the arbitration of both existing and future disputes which the parties have contracted to submit to the decision of arbitrators.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there have been no reported appellate court cases in North Dakota involving arbitration of medical malpractice claims, there does not appear to be anything in the Act which would serve as an impediment to its use for the resolution of medical malpractice claims. Statutory arbitration can, under Section 32-29-01 *N.D. Code Ann.* (1960), be used to settle any controversy which might be subject of a civil action between the parties. The only caveat is that persons entering into agreements to arbitrate must have the capacity to make a contract. The nature of the hearing and the power of the arbitrators would appear to be sufficient to insure an adequate consideration of the types of issues that could be involved in medical malpractice suits.

OHIO

I. STATUTORY FOUNDATION

Ohio has enacted an arbitration statute. *Ohio Rev. Code Ann.* Sections 2711.01 to 2711.15 (1953) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The Ohio act, which is comparable to the New York arbitration statute, is similar to the UAA. Dissimilarities between the UAA and the Ohio act are indicated in the analysis of the "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to Ohio's statutory arbitration scheme, Ohio courts have continued to recognize the validity of awards issued pursuant to common law arbitration. *Columbus, H.V. & T.R. Co. v. Burke*, 54 Ohio St. 98, 43 N.E. 282 (1896).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 2711.06 empowers arbitrators to "subpoena in writing any person to attend before any of them as a witness and in a proper case to bring with him any book, record, document, or paper which is deemed material in the case." The Section also prescribes a penalty which the Court of Common Pleas may exact for failure of a witness to appear or to bring any material requested by the arbitrators.

b) Section 2711.06 empowers arbitrators to administer oaths or affirmations to witnesses. However, their power is discretionary and testimony may be heard without first administering an oath.

c) The Act is silent as to whether strict evidentiary rules are observed in the conduct of the arbitration proceedings.

d) The Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this suggest that parties need not and do not as a matter of practice keep a transcript.

In *Hochwalt v. Rosser*, 28 Ohio Misc. Rptr. 253, 57 Ohio Opin.2d 490, 271 N.E.2d 325 (Ohio Com Plea 1971), the Court held that an arbitration award could not be set aside because no record was made of the proceedings before the arbitrator.

It is noteworthy that Section 2711.08 requires that the award made in an arbitration proceeding must be in writing, signed by the arbitrators and delivered to the parties in interest.

e) The Act is silent as to whether reporters may be brought to the arbitration proceedings. It would appear, however, that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present or that the arbitrators keep a transcript of the proceedings.

f) An award is final and binding on the parties where the award rendered conforms to the requirements of the submission and is reached without fraud, partiality or such manifest mistake as naturally works a fraud. *Foster v. Hartman*, 23 Ohio C.C. 583, 34 Ohio C.D. 411 (Cir. Ct. Cuyohoga Co. 1912).

In *Corrigan v. Rockefeller*, 67 Ohio St. 354, 66 N.E. 95 (1902), the Supreme Court of Ohio held that an arbitration award made pursuant to the Act's requirements is final and binding upon the parties. In *Corrigan*, parties entered into an agreement to submit to arbitration a dispute arising out of a trust. The parties expressly agreed that the arbitrators would hear and finally decide all issues of law and fact. Pursuant to the terms of the agreement, hearings were held and the arbitrators rendered an award with which the beneficiary took issue. In rejecting the complaining party's petition to set aside the award, the Court said that it does not lie with a party to a contract of submission to arbitration to complain of an award against him where the award rendered conforms in all respects to the requirements of the submission and is not the product of fraud or manifest mistake.

In sum, the Ohio courts have consistently held that awards of arbitrators made pursuant to the statute are to be construed liberally and set aside only upon grounds named in the statute. *Mock v. Bowan*, 2 Ohio C.C. 574, 14 Ohio C.D. 27 (Cir. Ct. Stark Co. 1902).

g) Grounds for judicial review are substantially identical to those of the UAA. Section 2711.10 (Court may vacate award) sets forth grounds for judicial review of arbitration awards.

h) The Act does not provide for trial de novo of the subject matter of arbitration awards. As indicated in the analysis of Question IV (h), the Ohio courts liberally construe arbitration awards. Where grounds for judicial review are satisfied and an award is vacated, the Ohio courts ordinarily remand the proceeding to newly chosen arbitrators for further hearings not inconsistent with the court's orders.

i) There are several procedural peculiarities in the Act. As previously discussed, Section 2711.07 gives the parties upon petition of the court a right to take a deposition in an arbitration proceeding where, for example, a necessary witness is not within the subpoena power of the arbitrators. Moreover, Section 2711.01 expressly invalidates provisions in contracts for arbitration of controversies arising out of collective or individual contracts between employers and employees in respect to terms or conditions of employment and controversies with certain exceptions (see 2711.01(b) (1)-(5)), involving the title or the possession of real estate.

j) No provision of the Act precludes its application to the settlement of personal injury claims.

k) While it would appear that the statute could be used to settle personal injury claims, there have been no reported appellate court cases where Ohio's arbitration act has been used to settle a personal injury claim.

l) Section 2711.01 expressly provides for the arbitration of an existing controversy or a future controversy where the parties have entered into a written agreement to submit such controversies to arbitration. *Hamilton v. Home Ins. Co.*, 137 U.S. 370, a7 S.Ct. 133, 34 L.Ed. 708 (1890).

In sum, an agreement to arbitrate is valid, irrevocable and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there are no reported appellate cases indicating that the Act has been used to resolve personal injury claims, it would seem that, since any controversy may be submitted to arbitration, medical malpractice disputes could be settled under the Act.

OKLAHOMA

I. STATUTORY FOUNDATION

Oklahoma has not enacted a general arbitration statute.

Pursuant to *Okla. Const.* Art. 6 Section 21, a Board of Arbitration and Conciliation has been established. Its purview is strictly limited to arbitration and conciliation of labor disputes. 40 *Okla. Stats. Ann.* Section 4. Hence, it is not appropriate for the settlement of medical malpractice claims.

II. RELATIONSHIP OF STATUTE TO UAA

Not applicable.

III. COMMON LAW ARBITRATION

While there is no general statutory arbitration in Oklahoma an arbitration may be had at common law. *Burke Grain Co. v. Stinchcomb*, 70 Okla. 89, 173 P. 204 (1918). However, stipulations to arbitrate all elements of future controversies are not enforceable because such stipulations deprive the courts of jurisdiction and are contrary to public policy. *Boughton v. Farmers Ins. Exchange*, 354 P.2d 1085 (Okla. 1960). The principle underlying this policy is that one may only bind himself after the right accrues. *Wilson v. Gregg*, 208 Okla. 291, 255 P.2d 517 (1953).

There are no Oklahoma cases on the scope of matter which is the proper subject for arbitration. However, the general rule is that absent a statutory prohibition or overriding public policy practically any known kind of dispute or controversy can be submitted to arbitration, whether it relates to legal or equitable matters or a personal or property right. *Carr v. Am. Ins. Co.*, 152 F. Supp. 700 (E.D. Tenn. 1957), or whether the dispute is public or private in nature. *Atchison, T. & S.F. Ry. v. Brotherhood of Locomotive Firemen & Enginemen*, 26 F.2d 413 (7th Cir. 1928). Jurisdiction is limited to those questions expressly submitted to arbitration. *Wright Lumber Co. v. Herron*, 199 F.2d 446 (10th Cir. 1952).

The arbitrator's award is final, *Mercury Oil Refining Co. v. Oil Workers Int. Union, C.I.O.*, 187 F.2d 980 (10th Cir. 1951). Judicial review may be had only where there is an allegation of fraud in procuring the award or if it is clearly erroneous on its face. *Inglis v. Trickey*, 172 Okla. 144, 45 P.2d 135 (1935). There is no trial de novo unless the pleadings state facts sufficient to avoid the award, as the award of an arbitrator has the same force as a judgment of a court of competent jurisdiction. *Scrivner v. McClelland*, 67 Okla. 51, 168 P.415 (1917).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

Not applicable.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Under Oklahoma's common law arbitration scheme, parties could agree to settle existing medical malpractice claims.

However, given the fact that the common law arbitration scheme lacks the procedural formalities and safeguards peculiar to statutory arbitration schemes, plus the lack of an established body of case law supporting the arbitration of existing medical malpractice claims through common law arbitration in Oklahoma, it seems questionable whether parties will choose to resolve their existing medical malpractice claims by this means.

OREGON

I. STATUTORY FOUNDATION

Oregon has enacted an arbitration statute. *Ore. Rev. Stat.* Sections 33.210–33.340 (1953) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

Although the Oregon Act is not modeled after the UAA, it is similar to the UAA in several respects. Dissimilarities between the statutes are indicated in the analysis of the "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Oregon courts have continued to recognize the validity of common law arbitration. *Shepard & Morse Lumber Co. v. Collins*, 198 Or. 290, 256 P.2d 500 (1953).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 33.280(1) empowers arbitrators a majority of them to "Compel the attendance of witnesses duly notified by either party, and to enforce from either party the production of all books, papers and documents the arbitrators deem material to the cause."

b) Section 33.280(2) empowers arbitrators to administer oaths or affirmations to witnesses. However, the arbitrator's power to administer oaths to witnesses is discretionary so that they may hear testimony from witnesses who are not under oath.

c) The Act is silent as to whether arbitrators when conducting hearings must observe strict evidentiary rules. Given the fact that arbitrators are not required to hear testimony from witnesses under oath, it would seem that strict evidentiary rules need not be observed. On the other hand, Section 33.320(1) provides that the refusal by an arbitrator to hear material evidence is grounds for judicial review.

d) The Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that parties need not and do not as a matter of practice keep a transcript.

e) The Act is silent as to whether reporters may be brought to the arbitration proceeding. It would appear, however, that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present or even that the arbitrators keep a transcript of the proceedings.

f) The arbitration award is final and binding on the parties subject to vacation or modification by the court pursuant to Section 33.330 where the grounds stated in Section 33.320 (Exceptions to award) are satisfied.

g) Grounds for judicial review are listed in Section 33.320 and are substantially identical to those of the UAA. Section 33.320 provides that a party against whom an award was made may take exception in writing to the award for any of the seven following causes: (1) The award was procured by corruption, fraud or undue means; (2) There was evident partiality on the part of any of the arbitrators; (3) The arbitrators' refusal to postpone hearing or hear evidence constituted "misconduct" which prejudiced the rights of a party; (4) The arbitrators exceeded their powers as defined by the agreement; (5) There was evident material miscalculation on the face of the award; (6) The arbitrators passed on material matters not submitted to them for determination; (7) The award was imperfect as a matter of form. *See Brewer v. Allstate Ins. Co.*, 248 Or. 558, 436 P.2d 547 (1968).

h) Section 33.330 provides that upon the filing of exceptions where it appears that the award should be vacated or modified the courts "may refer the cause back to the arbitrators with proper instructions for correction or rehearing." Section 33.330 further provides that "upon the failure of the arbitrators to follow said instructions, they shall have jurisdiction over the case and proceed to its determination." Thus, where arbitrators refuse to rehear a controversy, it would appear that the Court would hear de novo the dispute and enter its judgment on the cause.

i) As previously indicated, the Oregon Act is not modeled after the UAA. Yet unlike most states arbitration provisions which are not enactments of the UAA, Section 33.280(4) empowers arbitrators or a majority of them to "decide both the law and facts involved in the cause submitted to them."

The Act is also peculiar in that it specifically precludes the settlement of real estate title disputes or disputes arising out of the terms of employment under collective contracts between employers and associations of employees. Section 33.210.

j) No provision of the Act precludes the settlement of personal injury claims by arbitration.

k) The Act has been used to settle controversies over personal injury claims. *See*, Aster, *Judicial Review of Uninsured Motorist Arbitration Awards*, 48 Ore. L. Rev. 74 (1968).

l) Section 33.210 expressly provides that "All persons desiring to settle by arbitration any controversy . . . (except as indicated in i, *supra*,) may submit their differences to the award . . . of any . . . persons mutually selected."

Section 33.220 permits parties who have entered into a written contract to settle by arbitration disputes which might arise out of that contract. Such an agreement to arbitrate future disputes is valid, irrevocable and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given the increasing role Oregon's Act has played in the settlement of uninsured motorists disputes and given the fact that Section 33.210 provides that persons may submit "any controversy", with two exceptions not here relevant (*See* i, *supra*) to arbitration, it would appear that the Act could be used to settle medical malpractice claims.

PENNSYLVANIA

I. STATUTORY FOUNDATION

Pennsylvania has enacted an arbitration statute. *Pa. Stat. Ann.* Tit. 5, Sections 1–209 (1963 & Cum. Supp. 1971).

II. RELATIONSHIP OF STATUTE TO UAA

The Pennsylvania arbitration statute sets forth comprehensive provisions for both voluntary submission and compulsory submission and arbitration of disputes by contract.

In 1951, Pennsylvania instituted compulsory arbitration of small claims. "The essence of this system is a local-option statute (Section 30 [Cum; Supp. 1972]) authorizing each county to require that a board of arbitrators, composed of members of the bar (Section 31 [VII]), constitute the initial tribunal for trial of all civil actions involving less than [3,000] dollars and not involving title to real estate." *Legislation, Arbitration and Award – Study Predicts Effects of Increase in Jurisdictional Amount of Compulsory Arbitration*, 113 *U.Pa.L Rev.* 1119 (1965) (Some footnotes included in brackets) (Hereinafter referred to as *Legislation*).

In 1970, as predicted by *Legislation*, the Pennsylvania Legislature amended Section 30 of the compulsory arbitration statute and raised the jurisdictional amount of compulsory arbitration to 3,000 dollars. The bar and commentators have enthusiastically endorsed the compulsory arbitration plan. See, McDevitt, *Arbitration: Pennsylvania and Massachusetts Compulsory Plans, Ins. L.J.* 588 (1965); Rosenberg & Schubin, *Trial by Lawyer: Compulsory Arbitration of Small Claims in Pennsylvania*, 74 *Harv. L. Rev.* 448 (1961).

More than 50 counties throughout Pennsylvania have adopted the compulsory arbitration procedure. In analyzing the operation of compulsory arbitration, Judge McDevitt made the following comments:

> The members of the Board of Arbitration are instructed by the Rules of Court to conduct the hearing before them with "due regard to the law and according to the established rules of evidence which, however, shall be liberally

> construed to promote justice." They have the general powers of the court with respect to the general handling of the case, subject to the supervisory powers of the judge in charge.
>
> Arbitration Rules provide for an appeal within 20 days from the action of the board to the court of common pleas, except in Allegheny and Philadelphia Counties, where the appeal is directed to the county court. This consists of:
>
> 1) A notice of appeal;
> 2) An affidavit that the appeal is not taken for delay;
> 3) An appeal bond with sufficient surety in double the amount of the costs likely to accrue; and
> 4) A praecipe ordering the case for trial on the civil trial list.
>
> In addition, the appellant must pay all record costs accrued (including the witness bill) to the time of taking the appeal and repay for the use of the county all fees received by the board of arbitrators in the case in which the appeal is taken but not to exceed 50 per cent of the amount in controversy. An average appeal cost would be made up as follows:
>
> 1) Repayment of arbitration fees – $70.
> 2) Bond ($100) – $10.
> 3) Record costs of $15 – $20, and possibly a witness bill in a nominal amount.
> 4) Prothonotary and arbitration appeal – $7, plus jury trial demand – $4.
>
> The total cost of an appeal in Philadelphia or Allegheny County would be about $110, including cost of filing the appeal. It would be less in the other counties.

McDevitt, *supra*, *Ins.L.J.* at 591-592.

Not only does Title 5 provide for compulsory arbitration by its terms but it provides for voluntary submission (chapter 1) and arbitration where contracts contain provisions to submit future disputes arising out of the contract to arbitration as well as contracts entered into by the parties to resolve existing disputes.

Section 1 of the voluntary submission chapter (Sections 1-8) provides that parties may end any controversy, except controversies involving the title to real estate, by entering into a written agreement covenanting that their submission shall be made a rule of court and that they shall be bound by the award.

Chapter 3 of Title 5 sets forth general provisions as to arbitrators. Among the powers conferred on arbitrators are: (1) the power to issue subpoenas for the attendance of witnesses and to compel the production of books, papers and documents which the arbitrators deem material to the controversy. Sections 121(VI) and (I), 128; (2) the power to administer oaths. Section 121 (III); (3) the power to judge the competency and credibility of witnesses and the propriety of admitting any written evidence. Section 121 (II); (4) the power to cause a record of the proceeding to be kept where a party requests that a reporter be present at the hearings. Section 121 (VI); and (5) the power to decide both the law and fact that may be involved in the controversy.

Of course, it should also be recognized that the parties may appeal from a decision rendered pursuant to the compulsory arbitration provisions, and a trial de novo may be had.

For purposes of the analysis of the "Procedural Attributes of the Statute" (Question IV) the provisions of Chapter 4 of Title 5 (Sections 161-181) will be examined. (Chapter 4 is hereinafter referred to as Act).

The Pennsylvania Arbitration Act is modeled after the 1925 Uniform Arbitration Act which was withdrawn by the National Conference of Commissioners on Uniform State Laws in 1943 and superseded by the UAA in 1955.

Although the superseded Uniform Arbitration Act is considerably less comprehensive than the presently approved UAA, the Pennsylvania Act in most material respects is similar to the UAA. There are, however, dissimilarities between the Pennsylvania Act and the UAA:

1) Section 161, unlike Section 1 of the UAA, precludes the application of the Act to the settlement of "personal services" (employer-employee contracts);

2) Section 165 empowers the court of common pleas to make rules concerning the procedure and practice under the Act which are not inconsistent with the express provisions of the Act;

3) The Pennsylvania Act expressly provides that it is applicable to contracts providing for arbitration where the Commonwealth agency, municipal corporation or political division of the Commonwealth is a party. Section 176, 181;

4) The Pennsylvania Act provides a procedure whereby the arbitrators or the parties *with the approval of the arbitrators* may apply to the court for the determination of any legal question in accordance with the terms of the Uniform Declaratory Judgments Act. *Pa. Stat. Ann.* Tit. 12, Sections 831-846 (1963). Section 177.

Further dissimilarities between the Pennsylvania Act and the UAA are indicated in the analysis of the "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration the Pennsylvania courts have continued to recognize the validity of common law arbitration. *Freeman v. Ajax Foundry Products, Inc.* 398 Pa. 457, 159 A.2d 708 (1960).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 166 empowers arbitrators to summon in writing any person to attend before them as witness, and, in a proper case, to bring with him any book, record, document or paper which the arbitrators deem material as evidence in the controversy.

b) Section 166 requires that arbitrators shall only hear testimony given under oath. It states in pertinent part that

"All testimony shall be taken under oath or affirmation as is now provided in suits at law. . . ."

c) The Act is silent as to whether arbitrators are required to adhere to strict evidentiary rules in the conduct of arbitration hearings.

While the Act is silent as to the application of strict evidentiary rules in arbitration proceedings, the Pennsylvania courts have held that, while technical procedural safeguards incident to litigation are not applicable, arbitration requires for its validity the observance of certain minimum standards indispensable to a fair and impartial disposition of the merits controversy. Among the minimum safeguards required are (1) notice of the hearing, (2) the right to present evidence and be heard, and (3) the right to cross-examine witnesses testifying at the proceedings. *Cutshall v. O'Brien,* 6 Pa. D. & C. 2d 296 (1956).

d) Section 166 provides that, at the request of either party or the arbitrators, testimony which is given at the hearing must be taken stenographically and made a part of the record.

e) *See* Question IV (d), *supra.*

f) An arbitration award which is reached in accordance with the Act's provisions and is entered as a judgment of the court is final and binding on the parties.

It is a well established principle of law that, unless restricted by the agreement to arbitrate, arbitrators are the final judges of both law and fact and an award will not be reviewed, reversed or modified for mistake of either. *Shannon v. Pennsylvania Edison Co.,* 364 Pa. 379, 72 A.2d 564 (1950); *Aster v. Jack Aloff Co.,* 190 Pa. Super, 615, 155 A.2d 627 (1959).

g) Grounds for judicial review are similar to those of the UAA. More specifically, Section 170 (Motion to confirm award, grounds, rehearing) and Section 171 (Modifying or correcting award, grounds) set forth grounds for judicial review of arbitration awards.

In *Capecci v. Capecci, Inc.,* 11 Pa. d & C.2d 459 (1958), *affirmed,* 392 Pa. 32, 139 A.2d 563 (1958), the Court emphasized that an arbitrator is the final judge of both law and fact and his award is binding unless it can be shown by the complaining party that there was fraud, misconduct, corruption or some other irregularity on the part of the arbitrator which caused him to render an unjust, inequitable and unconscionable award.

To the same effect as *Capecci* is *Campbell v. Industrial Union of Marine & Shipbldg. Workers of America,* 52 Pa. D.&C. 597 (1945). The Court declared that an arbitrator's decision could not be vacated by any court unless the award was procured by corruption, fraud, or undue means; or unless the complaining party can show by clear and convincing evidence that the arbitrator was partial, and thereby substantially prejudiced the complaining party's rights, or that the arbitrator was guilty of misconduct or exceeded his powers.

h) There is no trial de novo of the subject matter of the arbitration under the Act. *See* Question IV (f) and (g), *supra.*

In *Majcher v. Bronder,* 22 Pa. D.&C. 218 (1962), *affirmed,* 401 Pa. 500, 165 A.2d 251 (1962), the Court held that in the absence of any evidence that the board exceeded its powers or imperfectly executed them, the court had no power to vacate the award or order a rehearing before the arbitrators.

i) There is a noteworthy judicial interpretation of the Act which has not been previously discussed.

The Pennsylvania courts have held that contracts to arbitrate entered into after the Act became effective in 1927 impliedly adopt the Act, and arbitration is controlled by the Act. *J.M. Davis Co. v. Township of Shaler,* 332 Pa. 134, 2 A.2d 708 (1939).

j) No provision of the Act precludes its application to the resolution of personal injury claims.

k) Although it would seem that the Act (Title 5, Chapter 4, Section 161-181) could be used to resolve personal injury claims, there appear to be no reported appellate court cases resolving such claims under the Act. However, it should be noted that personal injury claims have been resolved under the compulsory submission provisions of Pennsylvania's arbitration statute (Title 5, Chapter 2, Sections 21-81). As the Act is an integral and additional part of the Pennsylvania arbitration statute, it would appear that the Legislature contemplated that personal injury claims would be arbitrated under the Act.

l) Section 161 provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given the facts that (1) personal injury claims have been resolved under the compulsory submission provision of Pennsylvania's arbitration statute, (2) the Act, as an amendment to the Pennsylvania arbitration statute, was enacted to supplement existing arbitration rights, (3) the language of Section 166 which states that "any controversy" may be resolved under the Act and (4) the legislative and judicial policy favor arbitration, it could be concluded that the Pennsylvania courts would recognize the validity of and give effect to arbitration awards resolving medical malpractice claims which are reached in compliance with the Act's provisions.

RHODE ISLAND

I. STATUTORY FOUNDATION

Rhode Island has enacted an arbitration statute. *R.I. Gen. Laws* Sections 10-3-1 to 10-3-20 (Reenactment 1969) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

Although the Rhode Island Arbitration Act is not modeled after the UAA, it is similar to it. Dissimilarities between the two acts are indicated in the analysis of "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Rhode Island courts have continued to recognize the validity of statutory arbitration. *Blackstone Val. Gas & Elec. Co. v. Rhode Island Power Transmission Co.*, 64 R.I. 204, 12 A.2d 739 (1940).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 10-3-8 empowers arbitrators to subpoena witnesses. In pertinent part, it states that "The arbitrators . . . may summon in writing any person, to attend before them . . . as a witness, and in a proper case to bring with him or them any book, record, document or paper, which may be deemed material as evidence in the case." Section 10-3-8 further provides that "The summons shall issue in the name of the . . . arbitrators . . . and shall be directed to the said person and shall be served in the same manner as subpoenas to appear and testify before said Courts. If any person . . ., so summoned to testify, shall refuse or neglect to obey said summons, upon petition said court may compel the attendance of such person . . . before said . . . arbitrators, or punish said person . . . for contempt, in the same manner now provided for securing the attendance of witnesses or their punishment for neglect or refusal to attend said court."

b) Unlike UAA Section 7(a) which empowers arbitrators to administer oaths, the Rhode Island Arbitration Act does not afford arbitrators such power. However, Section 10-3-9 provides that upon petition approved by the arbitrators, the superior court for the county in which any of the parties reside or have their place of business "may direct the taking of depositions to be used as evidence in the same manner and for the same reason as provided by law for the taking of depositions in suits or proceedings pending in said court." This provision is similar to UAA Section 7(b) which empowers arbitrators upon application of a party to permit a deposition to be taken in accordance with the terms designated by the arbitrators. While the sections are similar, it should be noted that the UAA empowers arbitrators to permit depositions to be taken whereas the Rhode Island Arbitration Act affords arbitrators no such power but rather requires the superior court to direct the taking of depositions.

c) Both Rhode Island's Arbitration Act and case law are silent as to whether strict evidentiary rules are observed in arbitration proceedings. While the summoning of witnesses and the taking of depositions are treated in the same manner as would a court, there is no indication that the evidentiary rules observed in court must also be observed in arbitration hearings. Rather, it could be inferred from the fact that the grounds for vacating, modifying or correcting an award do not include the failure to conduct hearings in accordance with strict evidentiary rules that such rules are not observed.

On the other hand, Section 10-3-12(c) (Grounds for vacating award) requires the court to vacate an arbitration award where the arbitrators "refuse(d) to hear evidence pertinent and material to the controversy," and where the arbitrators heard "legally immaterial evidence" which substantially prejudiced the rights of a party to the arbitration.

d) Although Section 10-3-10 requires the award to be in writing and signed by the arbitrators joining in the award, the Act and case law are silent as to whether a transcript of the arbitration proceeding must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act is silent as to whether the parties may bring a reporter to the arbitration proceedings. Although the case law gives no indication as to whether the parties may agree to bring a reporter, it would seem that their agreement to arbitrate could be conditioned on the presence of a reporter at the arbitration proceedings or the making of a transcript of the proceedings.

f) Arbitration awards are final and binding on the parties to the arbitration unless the award is vacated, modified or corrected as prescribed in Sections 10-3-12 to 10-3-14. Indeed, Section 10-3-11 provides that the "court must grant" an order confirming the award where a party to the arbitration applies for such an order within one year after the award is made and grounds for vacating, modifying or correcting an award are not satisfied. *Joseph P. Cuddigan, Inc. v. Dimeo Const. Co.*, 261 A.2d 850 (R.I. 1970).

g) Grounds for judicial review of arbitration awards are substantially identical to those of the UAA. Section 10-3-12 (Grounds for vacating award) and Section 10-3-14 (Modification or correction of award) set forth the grounds for judicial review of arbitration awards.

h) There is no trial de novo by the courts of the subject matter of the arbitration controversy. Rather, as indicated in Question IV (f), the award is conclusive on the merits of all matters properly within the scope and intended by the arbitrators to be finally decided. Moreover, Section 10-3-13 provides that where an award is vacated, the court, in its discretion, may direct a rehearing by the arbitrators.

i) The Rhode Island arbitration statute is peculiar in that it specifically does not "apply to collective contracts between employers and employees or between employers and associations of employees, in respect to terms or conditions of employment." Section 10-3-2.

j) No provision of the Act prohibits its application to the resolution of personal injury claims.

k) While the Act would appear to be applicable to the resolution of personal injury claims (See Section 10-3-2), a review of the case law construing Rhode Island's arbitration provisions does not reveal any appellate court case where arbitration was used to settle a personal injury claim.

l) The Act is applicable to both agreements to submit existing disputes to arbitration as well as agreements to arbitrate future disputes. Section 10-3-2 specifically provides that an unambiguous condition in a written contract to settle by arbitration a controversy "thereafter arising out of such contract . . . shall be valid, irrevocable and enforceable, save upon such grounds as exist in law or in equity for the revocation of any contract . . . ." Furthermore, it provides that persons may agree in writing to submit "any controversy existing between them at the time of the agreement to submit (to arbitration)."

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there are no reported appellate court cases where the Act has been used to resolve personal injury claims, it would appear that the Act could be used to resolve personal injury claims. Section 12-3-2 which provides that the Act is applicable to "any controversy" which the parties agree in writing to submit to arbitration clearly encompasses controversies involving medical malpractice claims.

SOUTH CAROLINA

I. STATUTORY FOUNDATION

South Carolina has enacted an arbitration statute. *S.C. Code Ann.* Sections 10-1901 to 10-1905 (1962); And *See S.C. Const.*, Article 6, Section 1 (1962).

II. RELATIONSHIP OF STATUTE TO UAA

The South Carolina arbitration statute was enacted in accordance with the State's constitutional mandate. South Carolina Constitution Article 6, Section 1 provides that:

> The General Assembly shall pass laws allowing differences to be decided by arbitrators, to be appointed by the parties who may choose that mode of adjustment.

Implementing this constitutional mandate, the General Assembly has enacted and re-enacted arbitration provisions. The present arbitration statute, which is a direct descendant of an 1896 act, is neither modeled after nor similar to the UAA. Among the dissimilarities between the South Carolina statute and the UAA are: (1) The absence of procedural guidelines for the conduct of hearings; (2) the absence of provisions for compelling or staying arbitration; (3) the absence of a provision for the amendment of an award by the arbitrators; (4) the absence of a provision specifying expenses or fees; and (5) the absence of a provision stating grounds for judicial review of arbitration awards by the courts. All of these provisions are set forth in the UAA. Further dissimilarities between the statutes are indicated in the analysis of "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the South Carolina courts have continued to recognize the validity of common law arbitration. *Harwell v. Home Mutual Fire Ins. Co.*, 228 S.C. 594, 91 S.E.2d 273 (1956).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 10-1903 empowers duly appointed arbitrators "to subpoena witnesses and send for papers with the same powers and penalties as now apply to magistrates' courts."

b) The statute does not empower arbitrators to administer oaths. Moreover, the statute and case law are silent as to whether witnesses testifying at arbitration proceedings are under oath.

On the other hand, the South Carolina arbitration statute expressly requires that arbitrators take the following oath: "I do solemnly swear that I will duly consider all the evidence adduced by the several parties to this contention, and I will render a true verdict of findings according to law and the evidence." Section 10-1902. Furthermore, the statute specifies the manner in which arbitrators shall be selected. Section 10-1902, in pertinent part, provides: "The arbitrators shall be selected in the following manner: One discreet person shall be selected by each party to the contention, and the two so selected shall select a third person who shall not be connected with either of the principals by blood or otherwise."

c) Section 10-1902 requires arbitrators to take an oath in which they swear to render "a true verdict of findings according to law and the evidence." Although it could be inferred from this oath that arbitration hearings are conducted in accordance with strict evidentiary rules, it would appear from the case law that strict evidentiary rules need not and as a matter of practice are not observed in the conduct of arbitration proceedings.

In *Bollman v. Bollman*, 6 S.C. 29, 44-45 (1875), the Supreme Court of South Carolina explained that arbitration, like any judicial hearing, could not proceed without evidence and the right of the parties to present argument. However, while recognizing that arbitration contemplates and normally requires the receipt of evidence, the Court emphasized that arbitrators are not bound strictly to the rules of evidence when receiving testimony. *See Corbin v. Washington Fire & Marine Ins. Co.*, 278 F. Supp. 393 (D.S.C. 1968).

To the same effect as *Bollman* is *Mulder v. Cravat*, 2 Bay 370, 372 (1802). In *Mulder*, the court addressed itself to the question whether strict evidentiary rules need be observed in arbitration hearings and said that, in agreeing to arbitration, the parties "consent(s) that his (their) case *shall be no longer bound* by the rigid rules of law and evidence. . . ." (Emphasis added). See *also Askew v. v. Kennedy*, 1 Bailey 46,49 (1828).

d) Although Section 10-1905 requires that "The award of the arbitration shall be filed with the clerk of the court of common pleas within five days after such finding", the statute is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act and case law are silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings or even on the keeping of a transcript.

f) An arbitration award is final and binding on the parties where it is filed with the clerk of the court of common pleas within five days after the award is made and neither party appeals the arbitrator's decision. More specifically, Section 10-1904 in part provides: "The findings of the board of arbitration shall be final, except that either party shall have the right of appeal to the circuit court by serving written notice upon the opposite party within five days after the finding of the arbitrators, setting forth the grounds of the appeal." Section 10-1904 further provides that "If no such notice shall be given within five days after such finding the award of arbitration shall be final."

g) Grounds for judicial review are not set forth in the statute. Rather an aggrieved party may appeal any award to the circuit court by serving written notice upon the opposite party within five days after the arbitrators make an award.

The Courts, however, have judicially determined what grounds require an award to be set aside, modified or corrected.

In *Greenville County v. Spartenburg County*, 62 S.C. 105, 40 S.E. 147 (1901), an action was brought by the County of Greenville to enforce an award of the arbitrators determining the location of a boundary between two counties. In enforcing the arbitrators' award, the Supreme Court of South Carolina explained:

> . . . The object of submitting a controversy to arbitrators is to secure a settlement of the matter in dispute by a tribunal of the parties' own choosing, which shall do substantial justice without being restricted by technical rules of law. Courts favor awards, and will indulge every reasonable presumption to uphold them, and whoever assails them has the burden of clearly establishing their invalidity. . . . To avoid an award, the resisting party must show that the arbitrators (1) exceeded their power, in which case they may nevertheless be held valid as to the separable part of the award which is within the terms of the submission *(McCall v. McCall*, 36 S.C. 86, 15 S.E. 348); or (2) there must be shown fraud, corruption, or partiality on the part of the arbitrators; or (3) some gross and palpable mistake of law or fact, appearing on the face of the award, or by admission of the arbitrators, which materially affected the award, and made it operate contrary to the intention of the arbitrators. [Citation omitted]. The cases distinctly hold that the court will not retry the matter submitted to arbitration on its merits . . . . [T]he circuit court fell into error of practically retrying the dispute submitted to the arbitrators, and refusing to enforce the award because upon the testimony taken at the trial he reached the conclusion that the disputed boundary line had not been accurately located. There was no mistake of law on the part of the arbitrators . . . . Whether the boundary was correctly located upon the evidence submitted to the arbitrators, as the triers of such facts. Such was the dispute they were called upon to finally settle, and in the absence of any showing of fraud, corruption, or partiality, or gross and palpable mistake appearing on the face of the award, it must be held conclusive. *Greenville County v. Spartenburg County*, *supra*, 62 S.C. at 125, 40 S.E. at 154.

h) Section 10-1904 seems to empower the South Carolina courts to hear de novo the subject matter of arbitration. In pertinent part, it states: "On [appeal from an aggrieved party to the arbitration] the circuit judge presiding shall hear the appeal as to all questions of law and fact without the intervention of a jury."

Although the courts seemingly may hear de novo the subject matter of an arbitration, the South Carolina courts have held that the decision of the arbitrator when reached in the exercise of his honest judgment is conclusive, and the courts prohibit and refuse to hear de novo the merits of the arbitration. *Greenburg County v. Spartenburg County*, *supra; And See Brooke v. Laurens Mills Co.*, 78 S.C. 200, 58 S.E. 806 (1907); *Rounds v. Aiken Mfg. Co.*, 58 S.C. 290, 36 S.E. 714 (1900).

i) The South Carolina arbitration statute is peculiar in that there is an absence of provisions outlining procedures for hearings, procedures for vacating and modifying an award and procedures for compelling or staying an arbitration. See Question II, *supra.*

j) No provision of the statute prohibits its application to the resolution of personal injury claims. The South Carolina courts have held that a provision in an insurance policy to determine the amount of a party's liability, where liability is not contested, is enforceable. On the other hand, the South Carolina courts have held that a provision in an insurance policy which provides that a party's liability is to be determined by arbitration is unenforceable. *Childs v. Allstate Ins. Co.*, 237 S.C. 455, 117 S.E.2d 867 (1961).

k) While it would appear that the statute could be used to resolve the amount of personal injury claims, there have been no reported appellate court cases where such claims have been resolved under the statute.

l) The South Carolina arbitration statute authorizes parties to agree to submit existing controversies to arbitration. However, the statute is ambiguous as to whether agreements to submit future controversies to arbitration are valid. Section 10-1901 in part states: "Any and all persons, in case of disagreement or difference of opinion as to the proper settlement of any contention *that may hereafter arise*, may agree to leave their differences to arbitration." (Emphasis added). The language "hereafter arise" seems to refer not to future controversies but rather to the effective date of the statute.

While the South Carolina courts have not construed the language "hereafter arise" in Section 10-1901, it would appear that agreements to arbitrate disputes arising out of contracts are valid and binding, except where the issue of liability is purportedly determined. See *Corbin v. Washing-*

ton Fire & Marine Ins. Co., 278 F. Supp. 393 (D.S.C. 1968).

In *Childs v. Allstate Ins. Co.* 237 S.C. 455, 117 S.E.2d 867 (1967), the Supreme Court of South Carolina held that plaintiff-insured, who recovered a judgment against an uninsured motorist for personal injuries sustained in a collision, could recover his judgment from his insurer.

In holding the defendant-insurer liable for the insured's judgment, the court rejected the insurer's contention that arbitration of a disagreement between the insured and the insurer was, by the terms of the policy, a condition precedent to any action on the policy. The Court explained its holding as follows:

> The purported agreement for arbitration is unenforceable under the decisions of this court. *Jones v. Enoree Power Co.*, 92 S.C. 263, 75 S.E. 452; *Harwell v. Home Mut. Fire Ins. Co.*, 228 S C.594, 91 S.E.2d 273. (citation omitted). Such an agreement is upheld when it provides for arbitration of the amount of the loss but that at hand undertakes to require arbitration of the question of liability and is, therefore, not binding on the parties . . . .

The Court continued its explanation and quoted with approval 29 A Am. Jur. 699, Insurance, Sec. 1611 as follows:

> In accordance with general principles applicable to all contracts, it is the rule that a provision in an insurance policy that all disputes arising under the policy shall be submitted to arbitrators, or a provision similar in substance and effect, is not binding. On the other hand, the view prevailing in nearly all jurisdictions is that a stipulation not ousting the jurisdiction of the courts, but leaving the general question of liability for a loss to be judicially determined, and simply providing a reasonable method of estimating and ascertaining the amount of loss, is valid.

Childs v. Allstate Ins. Co., supra, 237 S.C. at 460, 117 S.E.2d at 869-70.

It should also be noted that parties agreeing to submit disputes to arbitration must "enter into a bond in double the amount involved." Section 10-1901.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

It would appear that medical malpractice claims could be arbitrated under South Carolina's arbitration statute only in limited fashion because an arbitration conducted pursuant to a term in an insurance policy, wherein the question of liability is purportedly resolved rather than the amount of loss, is unenforceable under South Carolina law. *Childs v. Allstate Ins. Co.*, 237 S.C. 455, 117 S.E.2d 867 (1967).

Section 10-1901 which recognizes the validity of an agreement to submit "any contention" to arbitration, appears to encompass the resolution of medical malpractice claims. While medical malpractice claims may be decided by arbitration under the statute, it should be recognized that Section 19-1901 requires "each party to enter into bond in double the amount involved [and to] faithfully . . . abide [by] the result of [the] arbitration." As medical malpractice claims frequently involve substantial damages, the requirement that a bond be posted in double the amount involved could prove to be a serious impediment to the arbitration of such claims.

SOUTH DAKOTA

I. STATUTORY FOUNDATION

South Dakota has recently enacted a Uniform Arbitration Act. *S.D. Stat. Ann.* Sections 21-25A-1 through 21-25A-38 (Supp. 1972). (hereafter Act)

II. RELATIONSHIP OF STATUTE TO UAA

The South Dakota Act is modeled after and is substantially identical to the UAA.

The only dissimilarities between the statutes are as follows:

(1) Section 21-25A-3 voids any arbitration provision in an insurance policy.

(2) Section 21-25A-6 leaves out the phrase "bona fides" that is found in UAA Section 2(e).

(3) Sections 21-25A-14 (Hearing by all arbitrators), 21-25A-15 (Evidence presented by parties) and 21-25A-17 (Adjournment or postponement of hearing) are prefaced by the caveat "Unless otherwise provided by agreement" which does not appear in Section 5, of the UAA counterpart. This difference could be significant because, under the Act, it would appear that the parties could agree to preclude themselves from being heard, cross-examining witnesses and presenting evidence material to the controversy without breaching "public policy."

While the South Dakota courts might not sanction such a broad construction of the phrase, it is likely that the phrase would be construed to mean: (1) the agreement itself could permit the hearing to be held with less than a majority of the arbitrators present or require all action to be taken with arbitrators present; (2) the agreement could limit the extent of cross examination at the hearing and (3) the agreement could affect the power of the arbitrators to adjourn or postpone the hearing.

(4) Section 21-25A-4 makes the circuit court the appropriate court of competent jurisdiction.

(5) Section 21-25A-2 provides that the Act is to apply only to agreements made subsequent to June 30, 1971.

III. COMMON LAW ARBITRATION

Not applicable.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 21-25A-12 clothes arbitrators with the power to issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 21-25A-12 empowers arbitrators to administer oaths. However, the power is discretionary and arbitrators are not required to administer oaths before taking testimony.

c) The Act is silent as to whether arbitration proceedings must be conducted in accordance with strict evidentiary rules.

However, the fact that the South Dakota legislature enacted a provision, Section 21-25A-36 (Uniformity of construction of chapter) which states that "This chapter shall be so construed as to effectuate its general purpose to make uniform the law of those states which enact it," suggests that the South Dakota courts would not require that arbitration proceedings be conducted in accordance with strict evidentiary rules. Adhering to the mandate of Section 21-25A-36, the South Dakota courts would probably follow the example of the Illinois courts and not require that the rules of evidence apply unless the agreement specifies otherwise.

d) The Act does not require that a transcript of the arbitration proceeding be kept. It would appear, however, that the parties could provide as a condition to their agreement to arbitrate that a transcript of the proceeding be made.

e) The Act is silent as to whether the parties may bring a reporter to the arbitration proceedings. It would appear however that the parties could provide as a condition to their agreement to arbitrate that a reporter be present at the proceedings.

f) While there has been no case law construing the finality of an arbitration award on the parties, it would appear from the face of the Act and from those states which have enacted and construed their uniform arbitration acts that an arbitration award made after a proceeding conducted in accordance with the Act's requirements would be final and binding on the parties.

More specifically, Section 21-25A-23 (Judicial confirmation of award) provides that upon application of a party the court shall affirm the award unless grounds are urged for vacating, modifying or correcting the award.

g) The grounds for judicial review are substantially identical to those of the UAA and are listed in Sections 21-25A-24 (Grounds for vacation of award), 21-25A-28 (Grounds for modification or correction of award), and 21-25A-35 (Appeals from orders, judgments and decrees).

h) There is no trial de novo of the subject matter of a validly arbitrated dispute. Section 21-25A-27 states that "In vacating the award on grounds other than the ground that there was no agreement to arbitrate and the party only participated under protest, the court may order a rehearing before new arbitrators. . . ."

i) There are no other peculiarities in the Act which have not been previously indicated

j) No provision of the Act prohibits agreements to arbitrate personal injury claims.

k) There are no reported appellate court cases where the Act has been used to arbitrate personal injury claims. However, it should be recognized that the Act which only became effective as to agreements made subsequent to June 30, 1971, has not yet had an opportunity to be widely utilized by contracting parties or judicially construed.

l) Section 21-25A-1 provides that a written agreement to submit any existing controversy or any controversy arising subsequent to a written agreemen to arbitrate is valid, enforceable and irrevocable save upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Examination of South Dakota sources reveals that the Act is still to be judicially construed.

While the Act has not spawned appellate case law indicating its application to the settlement of personal injury claims, there is no provision in the Act which would appear to impair its use for the settlement of medical malpractice claims.

TENNESSEE

I. STATUTORY FOUNDATION

Tennessee has enacted an arbitration statute. *Tenn. Code Ann.* Sections 23-501 to 23-519 (1955).

II. RELATIONSHIP OF STATUTE TO UAA

Tennessee's arbitration statute, a direct descendant of a statute compiled in the 1858 Code, is not modeled after the UAA. However, like the UAA, the statute sets forth guidelines for the conducting of hearings and the vacating, modifying and correcting of awards. Differences between Tennessee's arbitration statute and the UAA are indicated in the analysis of the "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

The Tennessee statute expressly preserves the validity of common law awards. Section 23-519 provides:

> Awards of arbitrators under agreements not reached in pursuance of this chapter, may nevertheless be valid, as contracts, impeachable for fraud or mistake; but such awards may only be enforced by independent actions.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) The Tennessee arbitration statute does not empower arbitrators to issue subpoenas. Rather, Section 23-509 provides that the clerk of the court or the justice may summon witnesses to appear before the arbitrators by subpoena.

b) Section 23-509 empowers arbitrators to administer oaths to witnesses testifying before them, but does not require arbitrators to swear witnesses before taking evidence. In pertinent part, it states:

> [W]itnesses may be sworn by any arbitrator, or umpire, and, if guilty of false swearing, they are liable to all the penalties of perjury, as if sworn in court.
>
> Witnesses are also subject to all the penalties prescribed by law, for failing to attend and give testimony, in pursuance of the subpoena, as well as in damages to the party injured by their default. . . .

c) Beyond requiring the arbitrators to give the party notice of the time and place of the hearing, and to take depositions to be used before the arbitrators, Sections 23-507, 23-509, the statute is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

d) Although Section 23-512 requires that "The award shall be in writing," the statute is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The statute and case law are silent as to whether the parties may agree to bring a reporter to the proceedings. Given the absence of an express prohibition, it would appear that the parties could condition their agreement to arbitrate on the presence of a reporter at the hearings or even on the keeping of a transcript.

f) An arbitration award reached in accordance with the provisions of the parties' agreement and the statute is final and binding on the parties. Section 23-504 sets forth the elements which agreements to arbitrate must contain. It provides that (1) the submission be by written agreement; (2) the demands to be submitted be specified; (3) the arbitrators be named or a method providing for their selection be specified; and (4) the court by which the judgment on the award is to be rendered be specified. Furthermore, like UAA Section 3, Section 23-504 of the Tennessee statute authorizes the court to appoint an arbitrator where, upon the petition of the adverse party, a party fails to appoint an arbitrator.

Where the parties enter their agreement to arbitrate as a matter of court record, it is irrevocable. Section 23-506. Of course, as the Supreme Court of Tennessee pointed out in *Kly v. Norrod*, 123 Tenn. 146, 136 S.W. 991 (1910), the statute only makes irrevocable those submissions entered of record. In short, to be irrevocable, the contract to submit to arbitration must be, like the award rendered as a result of the arbitration, entered as a matter of court record.

g) Unlike the UAA which sets forth a comprehensive list of grounds for judicial review of arbitration award, Section 23-514 of the Tennessee arbitration statute provides that "The award may be rejected by the court for any legal and sufficient reasons. . . ." However, as construed by the Tennessee courts, the grounds which have been held to be legally sufficient for vacating an award are similar to those of UAA Sections 12 and 13:

1) The award is a nullity unless it strictly conforms to the terms of the submission. *Toomey v. Nichols*, 53 Tenn. 159; *Palmer v. Van Wyck*, 92 Tenn. 397, 21 S.W. 761 (1893).
2) The award must totally dispose of the matter in dispute so that all that remains to be done to make the award final and binding is to have the court incorporate the award as a judgment.
3) The award is a nullity if it is obtained by fraud. *Mathews v. Mathews*, 48 Tenn. 669 (1870).
4) The award is a nullity if it is a product of evident partiality or a clear mistake of fact. See *Mathews*, *supra; Bought v. Ford*, 58 Tenn. 252 (1872).

Moreover, the Tennessee courts have rejected awards where the arbitration agreements intend that the arbitrators will reach their decisions in accordance with the rules of law and the rules have not been adhered to by the arbitrators. *State v. Ward*, 56 Tenn. 100 (1871). And where the arbitrators state the facts in the award as well as their deduction of law, the courts will determine whether they have drawn the proper conclusions. *Galbraith v. Lunsford*, 87 Tenn. 80, 9 S.W. 365 (1888).

h) The statute does not provide for a trial de novo of the subject matter of the arbitration. The award is res judicata and conclusive as to all matters embraced in the submission. *Hildebran v. Rowan*, 30 Tenn. 92 (1850). Of course, it should be recognized that while a valid award is res judicata, where it is not made a judgment of the court, it can only be enforced by suit since the arbitrators are not vested with power to enforce their decrees. *Collins v. Oliver*, 23 Tenn. 439 (1844).

Moreover, under Section 23-514 the courts are only authorized to reject awards for legal and sufficient reasons or to "[recommit] for a rehearing to the same or any other arbitrators agreed upon by the parties in writing."

i) Except for the prohibition of the resolution of disputes involving fee or life estates in land by arbitration under the statute, the statute has no noteworthy peculiarities. Section 23-501(2).

j) No provision of the statute specifically precludes its application to the resolution of personal injury claims.

k) Notwithstanding its long history and the absence of any bar precluding the resolution of personal injury claims under the statute, there are no reported appellate court cases where such claims have been resolved under the statute.

l) Section 23-501 expressly recognizes the validity of agreements to submit existing disputes to arbitration. In pertinent part, it provides: "All causes of action whether there be a suit pending therefor or not, may be submitted to the decision of one or more arbitrators. . . ." While there is no statutory language recognizing the validity of agreements to submit future controversies to arbitration, it appears from the case law that such agreements are valid.

In *R. Lee Tolley Co. v. Marr*, 12 Tenn. App. 505 (1931), the Court was called on to decide whether a provision in a building contract requiring an arbitration award to be reached before bringing an action on the contract was valid. In holding that the agreement to arbitrate disputes arising out of the award was valid, the Court said that such a provision did not oust the courts' jurisdiction in violation of public policy and that the provision to arbitrate conformed with the arbitration.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there are no reported appellate court cases where personal injury claims have been resolved under the statute, it would appear, given the absence of any provision prohibiting the statute's application to the resolution of medical malpractice claims, and given the broad language of Section 23-501 setting forth subjects of arbitration, that the Tennessee courts would recognize the validity of and give effect to awards resolving medical malpractice claims reached in compliance with the statute's requirements.

TEXAS

I. STATUTORY FOUNDATION

Texas has enacted an arbitration statute entitled "Texas General Arbitration Act". *Tex. Civ. Stat.* Art. 224-238 (Vernon Cum. Supp. 1972) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The Texas General Arbitration Act is modeled after and is substantially identical to the UAA. The Act differs from the UAA as follows:

1) Article 224 specifically precludes the application of the Act to "any labor union contract or to any arbitrations held pursuant to agreements between any employer and any employee of that employer or between their respective representatives, to any contract of insurance or any controversy thereunder, or to any construction contract or any document relating thereto."
2) Article 224, specifying the validity of arbitration agreements, states that "A written agreement concluded upon the advice of counsel to both parties as evidenced by counsels' signatures thereto to submit any existing controversy to arbitration or a provision in a written contract concluded upon the advice of counsel to both parties as evidenced by counsels' signatures thereto to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable save upon such grounds as exist at law or in equity for the revocation of any contract". On the other hand, UAA Section 1 does not limit the validity of agreements to arbitrate to those written agreements concluded upon advice of counsel, but rather recognizes the validity of written agreements whether with or without advice of counsel.
3) Article 230 (A) defines with greater particularity the power of arbitrators to administer oaths than does UAA Section 7(a). Article 230 (A) states: "The arbitrators shall have the power to administer oaths required by witnesses in a civil action pending in a district court and may cause same to be administered by any one of them, to each witness testifying before them."
4) Article 233, on fees and expenses of arbitrations as awarded by arbitrators, is more elaborate than its UAA Section 10 counterpart. In addition to the provision made in UAA Section 10, Article 233 provides that "Attorneys' fees shall be awarded by the arbitrators as additional sums required to be paid under the award only if provided for in the agreement to arbitrate or provided by law as to any recovery in a civil action in the district court on such a cause of action on which the award in whole or in part is based."
5) Article 235 sets forth a more detailed provision for the application to court and for the venue and jurisdiction of the court to which an application is made than do Sections 16, 17 and 18 of the UAA.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Texas courts have continued to recognize the validity of and to give effect to common law arbitration. *Carpenter v. North River Ins. Co.*, 436 S.W.2d 549 (Tex. Civ. App. 1968). While the enactment of the Texas General Arbitration Act did not deprive parties of common law arbitration, it should be recognized that their rights are considerably limited under common law arbitration. For example, it is a general rule that either party may revoke a common law submission to arbitrate at any time before an award has been made and proceed de novo in court. *Brown v. Eubank*, 443 S.W.2d 386 (Tex. Civ. App. 1969).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Article 230(c) empowers arbitrators to issue or cause to be issued by any one of them subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Article 230 empowers arbitrators to administer oaths but does not require that arbitrators administer oaths to any witnesses testifying before them.

c) Article 228 (b) states that "The parties are entitled to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing." Beyond these safeguards, the Act is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidentiary rules.

d) Although Article 231 (a) requires that "The award shall be in writing and signed by the arbitrators joining in the award," the Act is silent as to whether a transcript of the arbitration proceeding must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act is silent as to whether the parties may bring a reporter to the arbitration proceedings. Although the case law gives no indication as to whether the parties may agree to bring a reporter, it would seem that their agreement to arbitrate could be conditioned on the presence of a reporter at the arbitration proceeding or the making of a transcript of the proceedings.

f) Except where the grounds for opposing an arbitration award exist under Articles 237 and 238 or where the court declines to confirm an award on grounds other than those stated in Article 237 (a) (5) and orders a rehearing before newly chosen arbitrators, the arbitration award is final and binding on the parties. Moreover, the fact that the relief awarded was such that it could not or would not be granted by a court of law or equity is not ground for vacating or refusing to confirm the award.

The Texas courts have repeatedly stated that arbitration awards in matters properly submitted to arbitration are final and binding on the parties unless it be shown that the arbitrators were guilty of fraud, misconduct or such gross mistake as would imply bad faith or failure to exercise honest judgment. *Albert v. Albert*, 391 S.W.2d 186 (Tex. Civ. App. 1965); *Johnson v. American can Co.*, 361 S.W. 2d 451 (Tex. Civ. App. 1963).

g) Grounds for judicial review are substantially identical to those of the UAA. Article 237 (Vacating an award) and Article 238 (Modification or correction of an award) set forth grounds for judicial review.

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Rather, the courts can confirm, modify, or vacate the award or order a rehearing under the Act. Given the fact that the Texas courts have treated arbitration with favor, it would appear that Texas courts would continue to order rehearings before arbitrators rather than hear the dispute de novo.

i) Except as indicated in the analysis of the dissimilarities between the Act and the UAA (See Question II, *supra*), there are no peculiarities in the Act.

j) No provision in the Act precludes its application to the settlement of personal injury claims.

k) Although it would seem that the Act could be used to resolve personal injury claims, there has been no reported appellate court case where the Act has been used to resolve such a claim.

l) Although under prior Texas law provisions in contracts stating that any disputes arising out of the contract were to be settled by arbitration be viewed as an attempt to oust the courts' jurisdiction and thus be held invalid as against public policy, agreements to submit future disputes arising out of a contract to arbitration are enforceable under the Texas General Arbitration Act. *R.E.A. Exp. v. Missouri Pac. Ry. Co.*, 447 S.W.2d 721 (Tex. Civ. App. 1969). Article 224 provides that a contract executed with advice of counsel to submit existing as well as future disputes is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

A number of factors suggest that medical malpractice disputes could be resolved under Texas' Act. First, Article 224 of the Act recognizes the validity of written agreements concluded upon advice of counsel to resolve existing disputes or disputes subsequently arising out of the contract. While Article 224 precludes the application of the Act to several specific subject matters, medical malpractice claims is not one of those precluded subject matters. Secondly, the Texas Legislature enacted Article 238-4 which states that the Act shall be construed so as to make uniform the construction of those articles and sections that are enacted into the law of arbitration proceedings of other states. Adhering to the mandate of Article 238-4, it would appear that Texas courts could recognize and give effect to arbitration and arbitration awards involving medical malpractice claims. *See e.g.*, Arizona analysis *supra.*

In addition to these factors, it could be inferred from an examination of Texas law that the Texas courts might view the submission of medical malpractice claims with favor.

Texas has long favored arbitration as a means of settling disputes and every reasonable intendment will be indulged to support them. *Knutson v. Brayoria County*, 170 S.W.2d 843 (Tex. Civ. App. 1943), *affirmed*, 176 S.W.2d 710 (Tex. Sup. Ct. 1943); *Hill v. Walker*, 140 S.W. 1159 (Tex. Civ. App. 1911). Moreover, the Texas courts have asserted that statutes providing for arbitration should be liberally construed. *Temple v. Riverland Co.*, 228 S.W. 605 (Tex. Civ. App. 1921).

In sum, the provisions of the Texas General Arbitration Act and the position of the Texas courts with regard to arbitration in general suggest that arbitration awards resolving medical malpractice claims could be arbitrated in the same manner as other subject matters under the Act.

UTAH

I. STATUTORY FOUNDATION

Utah has enacted an arbitration statute. *Utah Code Ann.* Sections 78-31-1 to 78-31-22 (1953) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The Act is a version of the 1925 Uniform Arbitration Act (which was withdrawn in 1943 by the Commission on Uniform State Laws). *See* 9 ULA 76 (1957); and see *N.C. Gen. Stat. Ann.* Sections 1-544 to 1-549 (Repl. Vol. 1969). Consequently the Act's procedural mechanism and scope of application are far less comprehensive than that found in the present UAA, which was adopted by the Commission in 1955.

The Utah Arbitration Act differs from the UAA in many respects:

1) While the UAA empowers arbitrators to determine issues of law and fact and recognizes the arbitrators' decision is final and binding on the parties, the Utah Act establishes a procedure whereby parties to the arbitration may request that arbitrators submit questions of law arising in the hearing to the court, with the court's determination of that issue binding on the arbitrators. Section 78-31-13(1). Moreover, Section 78-31-13(2) of the Utah Act requires arbitrators, where a party requests, to state their final award in the form of a conclusion of fact so that the court may scrutinize the arbitrators' determination of questions of law. In contrast to this requirement, UAA Section 8(a) only requires that the award be made in writing and signed by the arbitrators joining in the award.

2) The Utah Act, unlike UAA Section 1 which is explicitly applicable to written agreements to submit existing and future disputes to arbitration, expressly limits its application to agreements to submit existing controversies to arbitration. Sections 78-3 78-31-2. *Johnson v. Brinkerhoff*, 89 Utah 530, 57 P.2d 1132 (1936).

3) Unlike UAA Section 2 which, upon application of a party showing an agreement to arbitrate, authorizes the Court to order the parties to proceed with arbitration, the Utah Act offers no similar procedural mechanism. On the other hand, it should be noted that Section 78-31-1, which states in part that "no party shall have the power to revoke the submission without the consent of the other parties to the submission," appears to make an agreement irrevocable.

4) The Utah Act limits the time within which an award may be made by the arbitrators. Although the UAA does not set a specific time limit for the rendering of an award where the parties have omitted a time limit, the Utah Act treats any award made after sixty days from the time of the appointment of the arbitrators as a nullity. Section 78-31-8.

Further procedural dissimilarities are indicated in the analysis of the "Procedural Attributes of the Statute" (Question IV).

III. COMMON LAW ARBITRATION

Although there have been no reported appellate cases affirming the continued validity of common law arbitration since the enactment of Utah's Act, the absence of any provision negating the common law right to arbitration suggests that parties may still avail themselves of common law arbitration to resolve their controversies.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 78-31-10 empowers arbitrators to issue subpoenas for any person to attend before them as a witness and to bring with him any book, writing or other evidence.

b) The Utah Act does not empower arbitrators to administer oaths, and it would appear that testimony given at arbitration hearings is not under oath. However, it should be noted that Section 78-31-11 provides that "Depositions may be taken . . . in the same manner . . . as provided by law for the taking of depositions."

c) The Utah Act and case law are silent as to whether strict evidentiary rules are observed in the conduct of arbitration proceedings.

d) Although Section 78-31-14 requires that "The award of the arbitrators . . . shall be drawn up in writing and signed by the arbitrators . . .", the Utah Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this question suggest that the parties need not and do not as a matter of practice keep a record.

In addition to the silence of the Act and case law as to whether a transcript of the arbitration proceedings must be kept, Section 78-31-20 supports the conclusion that a transcript need not be kept. Section 78-31-20, which lists the papers to be filed by a party moving for an order confirming, modifying, correcting or vacating an award, requires the filing of a written contract containing the agreement for the submission and the award and any other papers used upon the application to confirm, modify, correct or vacate the award. However, it does not require the filing of a transcript, and, in fact, is silent as to the existence of a transcript.

e) The Utah Act is silent as to whether reporters may be brought to the arbitration proceeding. It would appear, however, that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present or even that the arbitrators keep a transcript of the proceeding.

f) An award is final and binding on the parties where the award rendered conforms to the requirements of the submission and is reached without fraud, partiality or such manifest mistake as naturally works a fraud. *Richards v. Smith*, 33 Utah 8, 91 p. 683 (1907).

g) Grounds for judicial review are similar to those of the present UAA. More specifically, Sections 78-31-16 and 78-31-17 set forth grounds for judicial review of arbitration awards for the purpose of vacating or modifying them.

In *Bivans v. Utah Lake Land, Water & Power Co.*, 53 Utah 601, 174 P. 1126 (1918), the Supreme Court of Utah explained the grounds on which arbitration awards would be disturbed. First, the Court noted that arbitration awards would not be disturbed on account of irregularities or informalities or because the court does not agree with the award, so long as the proceedings are fairly and honestly conducted and the statutory rights of the parties are respected. The Court stated that the only grounds for disturbing an arbitration were those prescribed in the Act itself; it further emphasized that where such grounds (e.g., fraud, bad faith and "prejudicial imposition") are established, an award can be set aside notwithstanding any provision in the contract asserting that the award shall be absolute, conclusive and without appeal.

h) The Utah Act does not provide for a trial de novo of the subject matter of arbitration awards. Where an award is rendered in compliance with the Act's requirements, it is exhaustively reviewed the purpose of Utah's Arbitration Act, its operation, the grounds for a review of an award and the finality of an award.

In *Giannopulos*, an appeal from an order and judgment of the District Court of Salt Lake County confirming an award made by arbitration pursuant to the Act was taken to the Supreme Court of Utah. The parties, who were partners in the herding of sheep under a lease, entered into an agreement to submit to arbitration a dispute which arose between them. Pursuant to the agreement, a three man arbitration board was assembled, and, after considering the facts, they recommended a settlement in Pappas' favor. Pappas filed a motion to confirm the award, and Giannopulos, in response to the motion to confirm, filed a verified answer in which he urged that the award be annulled and vacated.

In resolving the case, the Supreme Court explained the nature of the proceedings under the operation of the Act:

> These proceedings were instituted under the provisions of the Uniform Arbitration Act, Laws of Utah 1927, C. 62, p. 100 [now *Utah Code Ann.* Sections 78-31-1 to 78-31-22 (1953)]. The act provides that two or more persons may agree in writing to submit a matter to arbitration: that the arbitration agreement must state the question or questions to be submitted with sufficient definiteness to present one or more issues or questions upon which an award may be based; that the arbitrators shall appoint a time and place of hearing and notify the parties thereof and may adjourn the hearing from time to time as may be necessary; that the award shall be in writing signed by the arbitrators or a majority of them and shall definitely deal with all matters of difference in the submission requiring settlement, or the arbitrators may in their discretion make partial award which shall be enforceable in the same manner as a final award; that at any time within three months after the award is made, unless time is extended, any party to the arbitration may apply to the court for an order confirming the award, and the court "shall grant such an order unless the award is vacated, modified, or corrected" as provided in the act. An order vacating the award may be made upon application of any party to the arbitration on the following grounds:
>
> a) "Where the award was procured by corruption, fraud or other undue means."
>
> b) "Where there was evident partiality or corruption in the arbitrators, or either or them."
>
> c) "Where the arbitrators were guilty of misconduct, in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to have evidence pertinent and material to the controversy; or any other misbehavior, by which the rights of any party have been prejudiced."
>
> d) "Where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award, upon the subject matter submitted was not made."

Giannopulos v. Pappas, supra, 80 Utah at 446-447, 15 P.2d at 355.

Continuing, the Court explained the effect and purpose of arbitration as follows:

> It is generally recognized by the authorities that the award of arbitrators, acting within the scope of their authority, determines the rights of the parties to it as efficiently as a judgment secured by legal procedure and is binding on the parties until set aside or its validity is questioned in some proper manner. [citation omitted]. The purpose of the law is to encourage persons who wish to avoid delays incident to legal action to obtain a settlement of their differences by arbitrators of their choosing. To this end arbitration is favored in the law as a speedy and inexpensive method of adjudicating differences by a tribunal whose award is final. Ordinarily a court has no authority to review the action of arbitrators to correct errors or to substitute its conclusion for that of the arbitrators' acting honestly and within the scope of their authority. [Citations omitted]. The statute has provided a method by which an award thus made may be given legal sanction and reduced to judgment by summary proceedings in the nature of a motion filed in court. The statute also has designated the grounds by which the award may be vacated or set aside, and it is generally held that no other grounds than those specified can be taken advantage of in such proceeding. [Citations omitted].

Applying these general standards, the Court scrutinized the substance of Giannopulos' motion to vacate the award and noted that the motion in substance alleged that one of the arbitrators was guilty of partiality and misbehavior which substantially prejudiced appellant's rights. After emphasizing that the parties have a right to be heard, that the arbitrators have a duty to hear all the evidence material to the matter in controversy and that a refusal to review material textimony is such misconduct as affords sufficient ground for setting aside the award, the Court held that Ginnaopulos' motion stated facts sufficient to furnish grounds for annulment of the award.

Having concluded that one of the arbitrators was guilty of misconduct within the meaning of Section 16(c), Act [now Act, Section 78-31-16(3)], the Court considered appellant's allegation that the parties had reached a verbal understanding that additional matters would be submitted to arbitration.

In rejecting this allegation, the Court held:

> . . . The statute requires that an arbitration agreement shall be in writing and state with

> sufficient definiteness the subject matter of the arbitration so as to present one or more issues or questions. It follows that the arbitrators were restricted to the issues or questions presented in the written agreement for arbitration and could not, without a supplemental agreement in writing, consider or determine other matters not mentioned in the original agreement. Appellant suffered no prejudice by reason of his inability to present, and consequently failure of the arbitrators to consider, any of the facts relative to the additional matter alleged to have been agreed between the partners to be submitted to arbitration. . . .

Giannopulos v. Pappas, supra, 80 Utah at 452, 15 P.2d at 357.

i) Aside from the peculiarities indicated in the analysis of Question II, there are not other noteworthy peculiarities in the Utah Act.

j) No provision in the Utah Act makes it inapplicable to the settlement of personal injury claims.

k) Although it would seem that the Act could be used to settle personal injury claims, there appear to be no reported appellate court cases where the act has been used to resolve personal injury claims.

l) Section 78-31-1 expressly recognizes the validity of written agreements to settle existing disputes by arbitration. In pertinent part, it states: "Two or more parties may agree in writing to submit to arbitration, in conformity with the provisions of this article, any controversy existing between them at the time of the agreement to submit." Moreover, Section 78-31-2 provides: "The arbitration agreement must state the question or questions in controversy with sufficient definiteness to present one or more issues or questions upon which an award may be based."

While the Act recognizes the validity of agreements to submit existing disputes to arbitration, it appears from the act and the case law that agreements to submit future disputes to arbitration are invalid.

In *Johnson v. Brinkerhoff*, 89 Utah 530, 57 P.2d 1132 (1936), the Supreme Court of Utah held that Section 78-31-1 provides for arbitration of disputes existing at the time the agreement to arbitrate is made and that it does not apply to agreements to arbitrate future disputes. *Barnhart v. Civil Services Employees Ins. Co.*, 16 Utah 2d 233, 398 P.2d 873 (1965); See also *Shumaker v. Utex Exploration Co.*, 157 F.Supp. 68, 72 (D. Utah 1957).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there appear to be no reported appellate court cases indicating that the Act has been used to settle personal injury claims, given the broad language of Section 78-31-1 stating that parties may agree to submit "any controversy" existing between them to arbitration, it would seem Utah courts would recognize the validity of arbitration awards resolving medical malpractice disputes reached in conformance with the Act's requirements.

VERMONT

I. STATUTORY FOUNDATION

Vermont has not enacted an arbitration statute of general applicability. Rather, the Vermont Legislature has only enacted a specialized statute applicable to labor management mediation and arbitration. *Vt. Stat. Ann.*, Tit. 21, Sections 501-513 (1967); And See Tit. 21, Sections 502-531(a) (Cum. Supp. 1971).

II. RELATIONSHIP OF STATUTE TO UAA

Not applicable.

III. COMMON LAW ARBITRATION

Although there is no arbitration statute of general application in Vermont, the Vermont courts recognize the validity of and give effect to common law arbitration awards.

An examination of the case law suggests that common law arbitration enjoyed a wide scope in the nineteenth century. Among the subject matters submitted to arbitration which were appealed to the Courts were disputes involving the possession of land, *Blanchard v. Murray*, 15 Vt. 548 (1843), and disputes involving special damages against a contractor who failed to perform his promise in accordance with the parties' written contract. *Hall v. Mott*, Brayton 81 (1820). In each of these cases the court confirmed the validity of submitting these disputes to arbitration.

While common law arbitration may have enjoyed broad application in the nineteenth century, its application in the twentieth century appears to have dwindled. Attenuation of the application of arbitration is strongly suggested by the small pool of appellate decisions on arbitration which have been handed down since the turn of the century. Not only does it appear that most of the "leading" common law arbitration cases were decided before 1900, but it appears that less than a dozen cases have been reported involving petitions to the courts seeking the vacation, modification or correction of a common law arbitration award.

The most recent reported case involving common law arbitration appears to be *Bernhardt v. Polygraphic Co. of America*, 122 F Supp. 733 (D.C. Vt. 1954). In *Bernhardt*, the Federal District Court held that an agreement to submit an issue to arbitration is not binding on the parties and is revocable at any time before an award is rendered by the arbitrators.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given the lack of development in the law of common law arbitration, and the resultant interestices in this area of the law, resort to the courts may be more practical than arbitration for resolving medical malpractice claims in Vermont.

VIRGINIA

I. STATUTORY FOUNDATION

Virginia has enacted an arbitration statute. *Va. Code Ann.* Sections 8-503 to -507 (Repl. Vol. 1957 & Cum. Supp. 1972) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The Virginia Act is markedly dissimilar from the UAA in many respects. Dissimilarities between the UAA and Virginia's Act are indicated in the analysis of the "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to Virginia's statutory arbitration scheme, Virginia courts have continued to recognize common law arbitration.

Under Virginia common law, two kinds of submission and award are recognized. The first is a submission in pais where, in the absence of any pending suit, parties agree to submit their existing controversies to arbitration. The second kind of a submission and award recognized is a submission made in a pending suit. Thus, it would appear that the Act is a supplementary mechanism designed to enlarge the common law arbitration scheme by providing an additional method of resolving disputes by arbitration.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) No provision of the Act clothes arbitrators with the power to subpoena witnesses. In contrast with the UAA, which explicitly authorizes arbitrators to subpoena witnesses, documents and other evidence, the Virginia Act does not equip arbitrators with any "judicial" power regarding the conduct of arbitration proceedings.

b) The Act is silent as to whether testimony at arbitration proceedings is given under oath. Unlike the UAA, arbitrators are not given the power to administer oaths by Virginia'a Act. Absent statutory authorization to administer oaths, it is likely that testimony is not given under oath.

c) While the Act is silent as to whether strict evidentiary rules must be adhered to in the conduct of an arbitration proceeding, Virginia courts have held that to be valid an arbitration award must be the product of proceedings fairly conducted.

In *Ligon v. Ford*, 5 Munf. (19 Va.) 10 (1816), the Supreme Court of Virginia invalidated arbitrators' award where they unreasonably refused to hear evidence of a competent witness offered by the complaining party. The Court asserted where arbitrators unreasonably refuse to hear competent witnesses offered by either party the arbitrators' award will be invalidated.

In *Bassett v. Cunningham*, 9 Gratt. (50 Va.) 684 (1853), the Court indicated that it is to be presumed that all improper testimony was discarded from the arbitrators' consideration in making their decisions. However, the Court emphasized that this presumption that improper evidence had been disregarded was because the arbitrators were selected because of their legal attainments.

Jenkins v. Liston, 13 Gratt. (54 Va.) 545 (1856), demonstrates that arbitrators must conduct proceedings in accordance with evidentiary rules. In *Jenkins*, the Court said if arbitrators admit "improper evidence" their award is thereby invalidated notwithstanding the fact that opinions were formed before such evidence was received. Moreover, in *Tate v. Vance*, 27 Gratt. (68 Va.) 571 (1876), the court invalidated an award where the arbitrators received evidence of one party during the absence of the other party.

In conclusion, the Virginia courts have consistently invalidated awards where failure to conduct proceedings in accordance with evidentiary rules undermined or may have undermined the fairness of the arbitration proceeding.

d) The Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that parties need not and do not as a matter of practice keep a transcript.

e) The Act is silent as to whether reporters may be brought to the arbitration proceedings. It would appear, however, that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present or even that the arbitrators keep a transcript of the proceedings.

f) At the outset, it should be noted that under Virginia's Act the submission of a controversy to arbitration is, when compared with the UAA, a complicated procedure.

Section 8-503 provides in pertinent part that

> Persons desiring to end any controversy . . . may submit the same to arbitration, and agree that such submission may be entered of record in any court. Upon proof of such agreement . . ., it shall be entered in the proceedings of such court; and thereupon a rule shall be made, that the parties shall submit to the award which shall be made in pursuant of such agreement.

Generally, the Virginia courts have held that while parties can agree to make arbitration a condition precedent to judicial litigation, parties cannot lawfully contract to deprive the courts of jurisdiction over their controversies.

On the other hand, awards made in accordance with the Act's procedures are by Section 8-505 final and binding on the parties. Moreover, Section 8-506 provides that "no such award shall be set aside except for errors apparent on its face, unless it appears to have been procured by corruption or other undue means, or that there was partiality or misbehavior in the arbitrators . . . " However, the final sentence of Section 8-506 introduces a caveat to the proposition that arbitration awards are final and binding on the parties. It states: "But this section shall not be construed to take away the power of courts of equity over awards." The effect of this provision in Section 8-506 is not clear. However, unlike the UAA, it suggests that awards which could not and would not be made by a court may be invalid.

g) Grounds for judicial review are stated in Section 8-506 which provides that an award may be set aside where (1) there are errors apparent on the face of the award; (2) the award was procured by corruption; (3) the award was the product of the arbitrators' partiality; and (4) the award is inequitable.

h) While the case law holds that an award may be set aside where the arbitrators make a material mistake of law in reaching their decision, the case law indicates that the Courts will correct the arbitrators' errors and remand the controversy to the arbitrators to be decided in accordance with the Court's opinion.

i) Virginia's Act is peculiar in several respects: (1) An arbitration clause in a contract may be a condition precedent to an action at law; (2) Section 8-507 expressly provides that fiduciaries may in good faith submit controversies to arbitration rather than proceed in court.

j) Virginia's arbitration Act does not prohibit the settlement of personal injury claims by arbitration. However, *Va. Code Ann.* Sections 8-634 to 8-637, 8-639 (Repl. Vol. 1957) prohibits arbitration where there has been a death covered by the wrongful death statutes.

k) While some personal injury claims could be settled by arbitration under Virginia's Act (*See* j *supra*), no recorded appellate case has been decided where the Act has been used to settle personal injury claims.

l) Section 8-503 expressly provides that persons desiring to end any controversy "whether there be a suit pending therefore or not" may submit the same to arbitration. This language clearly encompasses both existing and future disputes.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although there have been no reported appellate court cases where the Act has been used to settle personal injury claims, Section 8-503 provides that persons may submit "any controversy" to arbitration. Except for conflicts with the provisions in Virginia's Code regarding wrongful death actions, it would seem that this statutory language would permit parties to agree to submit medical malpractice claims to arbitration.

WASHINGTON

I. STATUTORY FOUNDATION

Washington has enacted an arbitration statute. *Wash. Rev. Code,* Sections 7.04.010 to 7.04.220 (1961) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

In 1943, the Washington Legislature amended the then existing arbitration laws. The Act is modeled after the old Washington act of 1881, but its scope is broader and it is more specific in providing legal machinery and forms which implement the Act's procedures for conduct of arbitration. Braman, *The 1943 Washington Arbitration Act,* 22 Wash. L. Rev. 117, 118 (1947) (hereinafter referred to as Braman).

In analyzing the Act's provisions, Braman listed the following differences between the act of 1881 and the 1941 Act:

> Major departures from the old act are the provisions (1) that future as well as present controversies may be the subject of written arbitration agreements, (2) that labor controversies may be the subject of arbitration under the act but are not within the act unless specifically so stated, and (3) that disputes involving title to real estate are not excepted from the act. Courts are also given more explicit power to enforce the arbitration of controversies, and to enforce, modify, or vacate an award.
>
> The act provides for voluntary, not compulsory, arbitration agreements. The purpose of such arbitration agreements is to provide an inexpensive, speedy, private, and effective method of deciding controversies out of court. This method is advantageous both to clients and to attorneys. Immediate settlement of controversies by arbitration removes the necessity of waiting-out a crowded court docket, of maintaining contact with witnesses for several months, and virtually eliminates, where the arbitration is well conducted, the expense and delay of appeals, as they are seldom taken. The controversy is heard by an arbitrator or arbitrators chosen, in most cases, by the parties themselves, thus assuring an arbitrator who is familiar with the problems involved in and peculiar to the immediate controversy—a benefit to all parties.

Braman, *supra,* 22 *Wash. L. Rev.* at 118-119 (Footnotes omitted).

Although the Act is not modeled after the UAA, its provisions in substance are similar to the UAA. Dissimilarities between the Act and the UAA are indicated in the analysis of the "Procedural Attributes of the Statute." (Question IV)

III. COMMON LAW ARBITRATION

Common law arbitration has been abolished in Washington. *Dickie Mfg. Co. v. Sound Const. & Eng. Co.,* 92 Wash. 316, 159 P. 129 (1916). Unlike the vast majority of states whose courts have held that statutory arbitration is not in derogation of the common law and have recognized the continuing validity of common law arbitration, the Washington courts have repeatedly held that only arbitration in conformance with the Act is valid. Arbitration and the rights of the parties' proceedings thus are wholly controlled by statutory provisions.

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 7.04.110 empowers arbitrators to require any person to attend as a witness, and to bring with him any book, record, document or other evidence. In compelling attendance, "Subpoena shall issue and be signed by the arbitrators, or any one of them, and shall be directed to the person and shall be served in the same manner as subpoenae to testify before a court of record in this state." Section 7.04.110.

b) Section 7.04.110 empowers arbitrators to administer oaths but does not require that oaths be administered before taking evidence.

c) The Act is silent as to whether the arbitration proceedings must be conducted in accordance with strict evidence rules. While the Act is silent, the Courts have determined the applicability of evidentiary rules in arbitration proceedings. In resolving an appeal from a judgment of a superior court approving an arbitration award reached in accordance with a predecessor statute, the Supreme Court of Washington, in *Puget Sound Bridge & Dredging Co. v. Lake Washington Shipyards*, 1 Wash. 2d 401, 407, 96 P.2d 257, 260 (1939), reviewed the Washington precedents and set forth the safeguards which are afforded parties at arbitration proceedings:

> An arbitration proceeding is judicial in nature, and its basic requisite, like that of all English and American jurisprudence, is that persons whose rights and obligations are affected thereby have an absolute right to be heard and to present their evidence, after reasonable notice of the time and place of the hearing. [Citations omitted]
>
> The decisions of this court are in accord with those principles.
>
> In Brown's Executors v. Farnandis, 27 Wash. 232, 67 P. 574, 576, the court, after referring to several instances of what it deemed to be irregularities on the part of the arbitrators, said:
>
> "While arbitrators are not required to proceed with the formalities of a court, they must proceed in such a manner as to give a full hearing to each of the parties, not only upon the several items of the claim presented by himself, but also upon the claim of his adversary, and upon the evidence adduced in support of that claim. This they cannot do without hearing a party and his witness in the presence of the opposing party. Unless this right is waived by the party, either in the agreement of submission or by conduct amounting to a waiver, an award, made under such circumstances is clearly void."

Puget Sound Bridge & Dredging Co. v. Lake Washington Shipyards, supra, 1 Wash.2d at 408, 96 P.2d at 260-261.

In sum, like the UAA, the Washington Act provides that parties to an arbitration have the right to be heard, to present evidence material to the controversy and to cross-examine witnesses appearing at the hearing. Furthermore, like the UAA, arbitrators are not bound by the "formalities of a court" in conducting arbitration hearings.

d) Although 7.04.140 requires that "The award shall be in writing and signed by the arbitrators or by a majority of them," the Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

e) The Act is silent as to whether the parties may bring a reporter to the arbitration proceedings. It would appear, however, that the parties could condition their agreement on the presence of a reporter at the proceedings or even the making of a transcript of the proceedings.

f) An award is final and binding on the parties where the award rendered conforms to the requirements of the submission, is reached without fraud, partiality or other statutory ground for vacating an award and is confirmed by the court. *Skagit County v. Trowbridge*, 25 Wash. 140, 64 P. 901 (1901).

Commenting on the finality of an award under the Act, Braman stated:

> The act provides that the court shall confirm an award made by an arbitrator unless the award should be vacated, modified, or corrected in accordance with the provisions in the act. Such a confirmation is a judgment, and may be enforced and appealed from an order of judgment in any civil action.

Braman, *supra*, 22 *Wash. L. Rev.* at 121 (footnotes omitted).

Furthermore, Section 7.04.070 expressly provides that arbitrators "may determine any question and render a final award."

g) Grounds for judicial review of arbitration awards are similar to the UAA. An award may be vacated upon application to the court by a party (1) where it was procured by corruption, fraud, or other undue means, (2) where the arbitrators were partial or corrupt, (3) where the arbitrators were guilty of misconduct which was prejudicial to the rights of any party, (4) where the arbitrators exceeded their powers or where the award was imperfect, or (5) where there were irregularities in the procedure. Section 7.04.160. However, an award may not be vacated upon any of these grounds unless the court is satisfied that substantial rights of the parties were prejudiced thereby. When an award is vacated, the court is required to direct a rehearing before the same or different arbitrators, according to its discretion. Section 7.04.160.

Furthermore, Section 7.04.170 (modification or correction of award) requires the courts to modify or correct an award where there is evident miscalculation of figures, property or other subject referred to in the award, where the arbitrators have awarded upon a matter not submitted to them and where the award is imperfect in a matter of form which does not affect the merits of the controversy.

In *St. Paul Insurance Companies v. Lusis*, 6 Wash. App. 205, 492 P.2d 575 (1971), the Court of Appeals, Division 2, held that the arbitrator's failure to disclose that he and one of the insured's counsel had a personal and professional relationship did not constitute sufficient ground to vacate the arbitrator's award.

In *Lusis*, respondent-insured, who was injured in an automobile accident with an uninsured motorist and who filed a claim under the uninsured motorist coverage of his automobile insurance policy with appellant-insurer, was awarded the policy limit by the arbitrator. Insurer petitioned superior court to vacate the award on the ground that the arbitrator's failure to disclose his personal and professional relationships with insured's counsel prejudiced insurer's right to a fair and impartial hearing.

Insurer sought vacation of the award, which was made in accordance with the rules of the American Arbitration Association, upon three statutory grounds: That the award was procured by (1) "undue means"; (2) "evident partiality"; or (3) "any other misbehavior, by which the rights of any party have been prejudiced."

In resolving the appeal, the Court said:

> In considering an application to vacate an arbitration award it is the function of the trial court to ascertain whether or not statutory grounds exist to vacate the award. In this state, arbitration proceedings are wholly statutory, and the rights of the parties thereto are governed and controlled by statutory provisions. In re Arbitration Puget Sound Bridge & Dredging Co. v. Lake Washington Shipyards, 1 Wash. 2d 401, 96 P.2d 257 (1939). The parties to an arbitration agreement may surround themselves with such procedural safeguards as they deem necessary and define the powers of the arbitrator, but violation of any such conditions need not necessarily coincide with a statutory ground for vacation of an award. Thus, our review is limited to whether or not there was a violation of any of the statutory provisions regulating the vacation of awards. More explicitly, under the factual pattern presented by this case, our concern is whether or not a violation of the AAA rules, if one took place, was sufficient to constitute a violation of one or more of the provisions of RCW 7.04.160. Northern State Constr. Co. v. Banchero, 63 Wash.2d 245, 386 P.2d 625 (1963).

St. Paul Insurance Companies v. Lusis, supra, 6 Wash. App. 492 P.2d at 577.

After reviewing a number of cases interpreting the AAA rule which declares that "an arbitrator shall disclose any circumstances likely to create a presumption of bias which might disqualify him as an impartial Arbitrator," the Court held that the arbitrator's failure to disclose his relationships with the insured's counsel did not constitute sufficient grounds to warrant vacation of the arbitrator's award.

h) The Act does not provide for a trial de novo of the subject matter of the arbitration. Where an award is rendered in compliance with the Act's requirements, it is a final and binding determination of the controversy which may not be disturbed unless statutory grounds exist. In short, the confirmed arbitration award is a final and binding determination of the issue and precludes a de novo determination of the same issue by a court or in a subsequent arbitration.

In commenting as to whether a review of the subject matter of an award could be reviewed de novo, Braman noted that

> Cases decided under a similar section of the old law have consistently held that an arbitrator decides both the facts and the law [*Hatch v. Cole*, 128 Wash. 107, 113, 222 P. 463, 464 (1924)], that the error must appear upon the fact of the award to be considered [*Puget Sound Bridge & Dredging Co. v. Frye*, 142 Wash. 166, 177, 252 P. 546, 550 (1927)], and that the court will not try a case *de novo* but in the event of error will return it for another hearing by an arbitrator [*Hatch, supra*, 128 Wash. at 114, 222 P. at 465].

Braman, *supra*, 22 *Wash. L. Rev.* at 121 (footnotes included in brackets).

i) Several provisions of the Washington Act are specially noteworthy. Section 70.04.060 requires the party demanding arbitration to serve upon the other party a written notice of his intention to arbitrate. "Such notice must state . . . that unless within twenty days after its service, the party served therewith shall serve a notice of motion to stay the arbitration, *he shall thereafter be barred from putting in issue the existence or validity of the agreement* or the failure to comply therewith." (Emphasis added).

Section 7.04.090 voids any award made after 30 days from the closing of the arbitration proceedings, unless the parties extend the time within which the award may be made or ratify an award rendered after the statutory limitation.

j) No provision of the Act precludes its application to the resolution of personal injury claims.

k) Although no provision of the Act precludes its application to the resolution of personal injury claims, there appear to be no reported appellate cases where such a claim was settled pursuant to the Act. On the other hand, it could be inferred from *Lusis, supra*, where personal injuries sustained in a collision with an uninsured motorist were remedied by arbitration conducted in accordance with the rules of the American Arbitration Association, that such claims could be resolved under the Act.

Support for this conclusion can be garnered from Braman's analysis of the scope of the Act's application:

> It will be noted that the act permits arbitration of "Any controversy which may be the subject of an action. [Section 7.04.010]. This embraces arbitration of tort or negligence claims, property settlements in divorce actions (though not divorce decrees) property disputes, industrial and labor controversies, price disputes, and other controversies too numerous to mention.

Braman, *supra*, 22 *Wash. L. Rev.* at 120-121 (footnote included in brackets).

l) Section 7.04.010 provides that a contract to submit existing as well as future disputes to arbitration is valid, enforceable and irrevocable except upon such grounds as exist at law or in equity for the revocation of any contract.

Moreover, it is interesting to note that in concluding his analysis of the Act, Braman stated:

> The legislature by this act has provided parties with a method of settling their present or future controversies by arbitration under their own written agreements. With thoughtful and clear drafting, and a sincere intention by all parties to avoid litigation and to solve their controversies amicably, this act can be expected to greatly reduce litigation in civil controversies; to facilitate settlement of disputes involving only nominal amounts; and to obviate much of the delay, worry, expense and hard feelings which so often accompany litigation.

Braman, *supra*, 22 Wash. L. Rev. at 124 (footnote omitted).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given (1) the broad application of the Act, (2) the legislative and judicial policy favoring arbitration, (3) the absence of any provision precluding the application of the Act to the resolution of personal injury claims, and (4) the *Lusis* case, *supra*, from which it could be inferred that personal injury claims can be arbitrated under the Act, it would appear that medical malpractice claims could be settled under the Act.

WEST VIRGINIA

I. STATUTORY FOUNDATION

West Virginia has enacted an arbitration statute. *W.Va. Code Ann.* Sections 55-10-1 to 55-10-8 (1966).

II. RELATIONSHIP OF STATUTE TO UAA

West Virginia's arbitration statute, a direct descendant of a statute first enacted in 1849, is neither based upon nor related to the UAA.

Differences between the West Virginia statute and the UAA are substantial. Unlike the UAA which provides a complete mechanism for the resolution of disputes by arbitration and whose enactment embodies a legislative concern for additional methods of resolving justifiable disputes, the West Virginia statute makes no provision for the formalities of a hearing and appears to be little more than a legislative approval of arbitration as a dispute settling mechanism.

Further dissimilarities between the UAA and the West Virginia statute are indicated in the analysis of "Procedural Attributes of the Statute". (Question IV).

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, common law arbitration is recognized in West Virginia. The statutory arbitration statute was enacted to implement and make more effective the common law arbitration procedures. *Hughes v. National Coal Co.*, 121 W.Va. 392, 3 S.E.2d 621 (1939).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) West Virginia's arbitration statute is silent as to whether arbitrators have subpoena power. In the absence of statutory authorization, it is unlikely that the West Virginia courts could deem arbitrators empowered with the judicial function of compelling witnesses to testify, or produce books, records, documents or other evidence.

b) West Virginia's arbitration statute is silent as to whether testimony at arbitration proceedings is given under oath. Given the absence of any provision empowering arbitrators to administer oaths or any provision requiring witnesses to be sworn by a court before testifying at an arbitration hearing, and given the absence of case law on the point, it is doubtful that testimony is given under oath.

c) In conducting arbitration hearings, strict evidentiary rules are neither observed as a matter of practice nor required as a matter of law. The West Virginia courts have said that the strict rules governing actions at law are not applicable to arbitration proceedings. *Boomer Coal & Coke Co. v. Osenton*, 101 W. Va. 683, 133 S.E. 381 (1926).

d) The West Virginia statute is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that parties need not and do not as a matter of practice keep a transcript.

e) The West Virginia statute is silent as to whether reporters may be brought to the arbitration proceedings. It would appear, however, that the parties could agree as a condition to submitting their controversy to arbitration that a reporter be present or even that the arbitrators keep a transcript of the proceedings.

f) An arbitration award is not final and binding on the parties unless the submission stipulates that the award is to be made a judgment of the court and a court of competent jurisdiction in fact enters judgment. *Simmons v. Simmons*, 85 W.Va. 25, 100 S.E. 743 (1919).

g) Grounds for judicial review of arbitration awards are substantially identical to those of the UAA. Section 55-10-4 (Setting aside award; equity jurisdiction not affected) and Section 55-10-6 (When award may be modified or corrected) set forth grounds for judicial review of arbitration awards.

h) While West Virginia's arbitration statute states grounds for judicial review of arbitration awards, it does not authorize the courts to hear de novo the controversy where those grounds are satisfied. Moreover, the Supreme Court of West Virginia has held that an arbitrator's decision on matters of fact and law is conclusive even where the court might have adopted a different decision. *Boomer Coal & Coke Co. v. Osenton*, 101 W.Va. 683, 133 S.E. 381 (1926); *Van Winkle v. Continental Fire Ins. Co.*, 55 W.Va. 286, 47 S.E. 82 (1902).

i) The West Virginia arbitration statute is peculiar in that it requires a submission to stipulate that the arbitration award be made a judgment of the court before a court may pass on the award and render it effective. Secondly, the statute is peculiar in that a submission of a pending cause of action is not revocable without leave of the court.

j) West Virginia's arbitration statute does not prohibit the settlement of personal injury claims by arbitration.

k) While it would seem that existing personal injury claims could be settled by arbitration under West Virginia's arbitration statute, no reported appellate case has used the statute to settle personal injury claims.

l) Section 55-10-1 specifically provides that "Persons desiring to end any controversy, whether there be a suit pending therefor ,or not, may submit the same to arbitration, and agree that such submission may be entered of record in any court. . . ." This language suggests that the statute is only applicable to existing controversies and not to controversies which might arise in the future. In fact, the Supreme Court of West Virginia held that contracts to submit any future disputes to arbitration are invalid under West Virginia Law. *Hughes v. National Coal Co.*, 121 W.Va. 392, 3 S.E.2d (1939).

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Although in its long history, no reported appellate case indicates that West Virginia's arbitration statute has been used to settle personal injury claims, it would nevertheless appear that *existing*, but not future, medical malpractice claims could be settled under its statutory arbitration scheme.

WISCONSIN

I. STATUTORY FOUNDATION

Wisconsin has enacted an arbitration statute. *Wis. Stat. Ann.* Sections 298.01 to 298.18 (1965) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

Although the Wisconsin Arbitration Act is not modeled after the UAA, its provisions are similar in substance to those of the UAA. It is noteworthy that the Wisconsin Constitution mandates the enactment of legislation guaranteeing, regulating and defining the powers of tribunals of conciliation. *Wis. Const.*, Art. 7, Section 16.

While the Wisconsin Arbitration Act and the UAA are similar in most material respects, there are differences between the two statutes. One notable dissimilarity is that the Wisconsin Act's scope of application is not as broad as the UAA's. Unlike UAA Section 1, the Wisconsin Arbitration Act expressly precludes the Act's application to the resolution of disputes arising out of contracts "between employers and employees, or between employers and associations of employees. . . ." Section 298.01.

III. COMMON LAW ARBITRATION

In addition to statutory arbitration, the Wisconsin courts have continued to recognize the validity of common law arbitration. *Allen v. Chase*, Wis. 249 (1854); *Reith v. Wynhoff*, 128 Wis.2d 236, 137 N.W.2d 33 (1965).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 298.06 empowers arbitrators to summon in writing any person to attend before them as a witness and in a proper case to bring with him any book, record, document or paper which may be deemed material as evidence in the arbitration. The summons directing a witness to attend must be signed in the name of and by the arbitrators and served in the same manner as subpoenas directing witnesses to testify before a court.

b) The Wisconsin Act does not empower arbitrators to issue oaths, and the Act and case law are silent as to whether witnesses testifying at arbitration proceedings must be under oath.

c) The Wisconsin Act is silent as to whether arbitration hearings must be conducted in accordance with strict evidentiary rules.

An examination of the case law construing the Act's predecessors suggests that arbitrators, beyond notifying the parties of the hearing and assuring them the right to be heard, present evidence and cross-examine witnesses testifying at the hearing, do not have to adhere to strict evidentiary rules. In *Koepke v. E. Leithen Grain Co.*, 205 Wis. 75, 236 N.W. 544 (1931), the Supreme Court of Wisconsin stated that where parties agree to submit a controversy to arbitration without restriction, the arbitrators are thereby empowered to decide questions of admissibility, competency and the weight of evidence. See also *Canfield v. Watertown Fire Ins. Co.*, 55 Wis. 419, 13 N.W. 252 (1182).

d) Although Section 298.08 states that "The award must be in writing and signed by the arbitrators or a majority of them," the Act is silent as to whether a transcript of the arbitration proceedings must be kept. The absence of any provision expressly requiring that a transcript be kept and the want of case law on this point suggest that the parties need not keep a transcript.

Further support for this conclusion can be inferred from Section 298.14 which lists the papers that must be filed when a party motions the court for an order confirming, modifying or correcting an award. This section does not require the filing of a transcript of the proceedings and, in face, is silent as to the existence of a transcript.

e) The Wisconsin Act is silent as to whether the parties may agree to bring a reporter to the arbitration proceedings. It would appear, however, that the parties could condition their agreement to arbitrate on the presence of a reporter at the proceedings or even the making of a transcript of the proceedings.

f) An arbitration award reached in compliance with the Act's provisions and which is entered as a judgment of the court pursuant to Section 298.09 is final and binding on the parties.

In *Travelers' Ins. Co. v. Pierce Engine Co.*, 141 Wis. 103, 123 N.W. 643 (1909), the parties pursuant to their agreement, submitted the question as to the amount of damages due the injured party. After noting that the submission authorized the arbitrator to resolve all questions of law and fact in determining the amount due the injured party, the Court held that the power of the arbitrator was as broad as that of the court and that if he honestly exercised his best judgment in rendering an award, his decision is final.

Moreover, it is a well established principle of law in Wisconsin that the burden of proof is on the party complaining that the award is invalid. An invalidity of an award must be shown by clear and convincing evidence. *Koepke v. E. Liethen Grain Co.*, 205 Wis. 75 236 N.W. 544 (1931); *In Re Lower Baraboo River Drainage Dist.*, 199 Wis. 230, 225 N.W. 331 (1929).

g) Grounds for judicial review are similar to those of the UAA. More specifically, Section 298.10 (Vacation of award, rehearing by arbitrators) and Section 298.11 (Modification of award) set forth grounds for judicial review of arbitration awards.

One of the prerequisites of a valid arbitration award is that it be final and determinative of the controversy submitted. This requirement, which is a standard ground for vacating an award, is intended to diminish the possibility of stimulating new controversies and litigation as the result of incomplete awards. *Goldmann Trust v. Goldmann*, 26 Wis.2d 141, 131 N.W.2d 902 (1965).

Before the Wisconsin Courts will void an award for mistake, a complaining party must show that the mistake appears on the face of the award or that is is so gross that the award results in an injustice to the parties or is tantamount to constructive fraud. *Putterman v. Schmidt*, 209 Wis. 442, 245 N.W. 78 (1932); *Stubbings v. McGregor*, 86 Wis. 248, 56 N.W. 641 (1893). It should be noted that mere mistakes of judgment, fact or law are not grounds for review of or setting aside an arbitration award. *Putterman v. Schmidt*, 209 Wis. 442, 245 N.W. 78 (1932); *Standard Const. v. Hoeschler*, 245 Wis. 316, 14 N.W.2d 12 (1944).

h) There is no trial de novo of the subject matter of an arbitration award. An award made in compliance with the Act's provisions is a conclusive determination of the issues submitted to the arbitrators and may not be reviewed by the court or in a subsequent arbitration. *Koepke v. E. Liethen Grain Co.*, 205 Wis. 75, 236 N.W. 544 (1931).

Moreover, the Act provides that where an award is vacated or modified the courts may direct a rehearing by the arbitrators.

In construing the effect of an arbitration award in *Dehnart v. Waukesha Brewing Co.*, 21 Wis.2d 583, 124 N.W.2d 664 (1963), the Supreme Court of Wisconsin announced the generally recognized principle of law that the doctrine of res judicata is applicable to a final arbitration award made in compliance with the Act's provisions.

i) The Wisconsin Arbitration Act is peculiar in that it provides, where the parties fail to appoint arbitrators, that the arbitration shall be by a single arbitrator unless the agreement specifies a different number.

It is also noteworthy that the Wisconsin Supreme Court has held that every contract subject to Wisconsin law containing an arbitration agreement, and not clearly negating the Act impliedly incorporates the provisions of the Act and is controlled by its procedures. *City of Madison v. Frank Lloyd Wright Foundation*, 20 Wis.2d 361, 122 N.W.2d 409 (1963).

j) No provision of the Act precludes its application to the resolution of personal injury claims.

k) There have been reported cases where the Wisconsin Act has been used to resolve personal injury claims. *See, e.g., Kane v. City of Fond du Lac*, 40 Wis. 495 (1876). In *Schramm v. Dotz*, 127 N.W.2d 779, 23 Wis.2d 678 (1964), the Court recognized the validity of resolving personal injury and property damage claims pursuant to the Act as provided by uninsured motorist clauses. The parties could not agree as to the amount of damages and the insured, contrary to the policy, instituted a legal action instead of seeking arbitration as required by the policy. However, insurer, by insisting on the dismissal of insured's action rather than seeking a stay for the purpose of securing a court order compelling arbitration as provided by Section 298.03, was held to have waived his right to arbitration.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

Given (1) the resolution of personal injury claims under the statute, (2) the broad language of Section 298.01 which states that "any controversy" may be submitted to arbitration and (3) the legislative and judicial policy favoring arbitration, it would appear that medical malpractice claims could be settled by arbitration under the statute.

WYOMING

I. STATUTORY FOUNDATION

Wyoming has recently enacted a uniform arbitration act. Uniform Arbitration Act, *Wyo. Stat. Ann.* Sections 1-1048.1 to 1-1048.21 (Cum. Supp. 1971) (hereinafter Act).

II. RELATIONSHIP OF STATUTE TO UAA

The Wyoming Act is modeled after and is substantially identical to the UAA. The only dissimilarities between the Act and the UAA are as follows:

1) It omits UAA sections 15 (Judgment Roll, Docketing), 22 (Constitutionality), 23 (Short Title) and 24 (Repeal).

2) Section 1-1048.9 designates "District Court" as the appropriate standard for measuring fees for witnesses

attending arbitration proceedings (counterpart provision: UAA section 7).

III. COMMON LAW ARBITRATION

Although Wyoming enacted its Act in 1959, the Wyoming courts recognize the right to and enforceability of common law arbitration. *Wyo. Riverton Valley Elec. Ass'n v. Pac. Power & Light Co.*, 391 P.2d 489 (Wyo. 1964).

IV. PROCEDURAL ATTRIBUTES OF THE STATUTE

a) Section 1-1048.9 clothes arbitrators with the power to issue subpoenas for the attendance of witnesses and for the production of books, records, documents and other evidence.

b) Section 1-1048.9 empowers arbitrators to administer oaths. However, the power is discretionary and arbitrators are not required to administer oaths before taking testimony.

c) The Act is silent as to whether arbitration proceedings must be conducted in accordance with strict evidentiary rules.

However, the fact that the Wyoming legislature enacted a provision, Section 1-1048.21 (Construction of Act) which states that "This act (Sections 1-1048.1 to 1-1048.21) shall be so construed as to effectuate its general purpose to make uniform the law of those states which enact it," suggests that the Wyoming courts would not require that arbitration proceedings be conducted in accordance with strict evidentiary rules. Adhering to the mandate of Section 1-1048.21, the Wyoming courts would probably follow the example of the Illinois courts and not require that rules of evidence apply unless the agreement specifies otherwise.

In *Gaddis Min. Co. v. Continental Materials Corp.*, 196 F. Supp. 860 (D.C. Wyo. 1961), the federal court held that an arbitration award could not be invalidated because of a party's lack of opportunity to cross-examine experts who were authorized to assist the arbitrators where cross-examination was not contracted for by the parties. Moreover, the Court noted that the parties' stipulation to submit to the arbitrators all relevant data they had concerning matters in dispute did not require that only such data be used by the arbitrators in their decision.

d) The Act does not require that a transcript of the arbitration proceeding be kept. It would appear however that the parties could provide as a condition to their agreement to arbitrate that a transcript of the proceeding be made.

e) The Act is silent as to whether the parties may bring a reporter to the arbitration proceedings. It would appear however that the parties could provide as a condition to their agreement to arbitrate that a reporter be present at the proceedings.

f) Section 1-1048.13 (Confirmation of award by court) provides that upon application of a party, the court shall confirm an award, unless grounds are urged for vacating, modifying or correcting the award. Thus it would appear on the face of the statute that an arbitration award made after a proceeding conducted in accordance with the Act's requirements would be final and binding on the parties.

g) The grounds for judicial review are substantially identical to those of the UAA and are listed in Sections 1-1048.11 (modification or correction of award), 1-1048.14 (when court to vacate award) and 1-1048.15 (when court to modify or correct award).

h) There is no retrial de novo of the subject matter of a validly arbitrated dispute. Section 1-1048.14 (5) (c) states that "In vacating the award on grounds other than [the ground that there was no agreement to arbitrate and the party only participated under protest], the court may order a rehearing before new arbitrators . . . ."

i) There are no other peculiarities in the Act which have not been previously indicated.

j) No provision of the Act prohibits agreements to arbitrate personal injury claims.

k) Although there are no reported appellate cases where the Act has been used to arbitrate personal injury claims, it would seem that parties could contract to arbitrate personal injury claims.

l) Section 1-1048.3 provides that a written agreement to submit any existing controversy or any controversy arising subsequent to a written agreement to arbitrate is valid, enforceable and irrevocable save upon grounds as exist at law or in equity for the revocation of any contract.

V. MEDICAL MALPRACTICE ARBITRATION POTENTIAL

While the Act has not spawned any appellate case law indicating its application to personal injury claims, there is no provision in the Act which would appear to impair its use for the settlement of medical malpractice claims.

THE EXPERIENCE OF BINDING ARBITRATION IN THE ROSS-LOOS MEDICAL GROUP

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Introduction

Shortly after it was established in 1929, Ross-Loos Medical Group instituted binding arbitration as an alternative to courtroom litigation of medical malpractice claims. Because it is a closed panel group, with a majority of patients entering the plan through union contracts, the logistics of achieving arbitration contracts with patients has not been difficult.[1] Union representatives ordinarily sign a master health care contract with Ross-Loos, and the arbitration agreement is a part of this contract. As discussed below, although the arbitration agreement is featured prominently in literature given to all new patients, patients frequently prove to be unaware of this fact at the time they initiate malpractice litigation. The California Supreme Court has not held that this unawareness invalidates the arbitration contract.

Arbitration at Ross-Loss clinic is more than a procedural device designed to obviate the many disadvantages of customary malpractice litigation. It is an integral part of a

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[1] The medical groups currently using binding arbitration in California (Southern California-Kaiser Health Plan, eight hospitals participating in a pilot study sponsored by the California Medical Association and California Hospital Association, several hundred physicians insured by Casualty Indemnity Exchange, and Ross-Loos Medical Group) achieve the arbitration agreement upon first contact with the patient—or with old patients when the institutions or physicians undertake this arrangement with their insurance carriers. One might anticipate that a closed panel group would have an easier time in obtaining patient consent to arbitration as compared to the private physician. However, although the experience of Casualty Indemnity Exchange is not analyzed for this report, an initial investigation of it indicates that few physicians find any difficulty in entering into arbitration agreements with more than 90% of their patients. (The 90% figure is required by CIE in order for the physician to achieve a premium discount on his insurance policy.)

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patient–oriented policy dating back to the origins of the medical group and the philosophy of its founders. The *broad* utility of arbitration, then, is difficult to determine in this particular context.

There is an additional element which precludes a definite conclusion regarding the utility of arbitration. Many plaintiffs' attorneys fail to pursue their cases against Ross-Loos when they discover they must be arbitrated. The attrition rate of cases filed in the Superior Court, and then directed to the proper venue, conclusively proves this point. This phenomenon was completely unanticipated, and it raises some important questions.

There is one unequivocal effect of arbitration at Ross-Loos. This is the psychological impact on the group's physicians. Interviews with department heads and other physicians reveal a peace of mind with regard to malpractice issues which is remarkable among California practitioners. This does not mean, however, that there are no financial pressures at work to reduce medical injuries. Because the partnership has always had an all-expense retention ($25,000 until recent years and $200,000 at the present time), there is an added motivation for peer review and control of medical conduct.

This loss retention has another effect, and one which is profound: Only twice has Ross-Loos paid an indemnity in excess of their retention. As a result, the insurance carrier has never been significantly involved with claims management. Claims are handled by the group's medical director in consultation with medical department heads and other involved personnel. This permits a freedom of action unconstrained by insurance company policies. Perhaps more importantly, the ability to deal directly with the complaining patient permits rapid handling of claims with no red tape. A side effect of this local management, and one which has affected both the statistical analysis in this report and the availability of closed cases for study, is the informality of record keeping. There is no central file identifying closed malpractice claims prior to 1964.[2] At no time has the administration kept track of claims incidence or cost per closed claim, etc.

The case analyses in this study concern 177 active and closed files at Ross-Loos Medical Group. Of these, 35 are closed cases, indemnity having been paid in all but two. These closed cases date back to 1964, cases prior to that time being unavailable.

The additional 144 cases, all of them active, constitute what might be characterized as potential claims. Again, because Ross-Loos does no insurance adjusting in any usual sense, and regards these potential claims not from the point of view of satisfying some insurance methodology with regard to their handling but only as a possible source of loss which the partnership's retention of $200,000 almost certainly would cover, the approach to these potential claims is homespun. The executive secretary to the clinic director handles problem cases as part of her various duties. She makes the decision whether a complaint might require administrative attention and these files are channeled from the various clinics, after each of the patient's visits, back to her office rather than being kept in the clinic's file cabinets. What is the nature of these 144 potential problem cases?

By no stretch of the imagination do they all constitute "claims" in any insurance sense. In insurance parlance the claim is a case which may someday result in a loss. These cases usually will require a reserve. And they will enter into statistical evaluations of claims incidence, cost per closed claims, percentage of claims resulting in indemnity paid, etc. But these 144 files at Ross-Loos break down to less than one third which, by very lenient criteria, might be characterized as "claims." And even this group would have to be further pared if one were to apply a critical standard. These files cover only 1970 and 1971. No estimate of claims incidence prior to that time is possible because statistics on these problem cases have not been kept, and as problems were resolved the files were returned to their clinic situs.

Lacking reliable data on claims incidence and loss per closed claim, the best statistical estimate of the Ross-Loos liability experience is gained by breaking down the indemnity and cost factors into cost per doctor year. The indemnity has been extraordinarily low for some years (1968 through 1970, for example) but relatively high in those years when a single loss sharply altered the averages. This is a function of a relatively small number of physicians, 125 full time positions at the present time filled by about 150 physicians.

It is important to note that Ross-Loos Medical Group has the only extended experience in binding malpractice arbitration in the country. Yet their actual experience with completed arbitrations is only 3 cases. This is a function of the group's willingness to settle cases (often on the eve of an arbitration.) It is the experience of Southern California-Kaiser especially, and also the experience of Casualty Indemnity Exchange and of the eight-hospital pilot project, which will supply the bulk of the binding arbitration cases over the next few years. Therefore, two or three years from now we will have a clearer view of the value of binding arbitration. Nevertheless, the Ross-Loos experience provides enough information for several reasonably definite conclusions. These are discussed in the Summary and Conclusions sections of this paper.

Legal Aspects of Binding Arbitration in California

Binding arbitration in malpractice cases must be differentiated from panel arbitration. The latter is an ad hoc proceeding, ungoverned by statutory law, and is usually entered into pursuant to stipulation *following* a medical injury. Most of the existing panels place no burden on the loser; he may go on to courtroom litigation if he wishes.

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[2] The Ross-Loos administration feels confident that they can identify significant medical injuries within a short time of their occurrence. Therefore, some old records are destroyed which, in a private physician's office, might be better preserved. Additionally, there are old records in permanent storage, and there is no means of identifying files in that group which may have been associated with some indemnity paid prior to 1964. Failure to preserve statistics would be critical for an insurance carrier, but it is not of great moment for a group which is virtually self-insured.

The binding arbitration contract is normally signed in anticipation of *future* disagreement. The California Code of Civil Procedure (CCP), Title 9 (Section 1280 et seq), sets out the relevant law. California has had arbitration statutes since the original Field Codes of 1872 with major statutory revisions in 1927 and 1961. They are characterized by an absence of legal technicalities, the informality of the hearing, and the finality of the arbitrators' decision. The California statutes anticipate a neutral arbitrator selected by the parties or appointed by the Superior Court if the parties can't agree.[3] There is no requirement as to the situs of the hearing. As in a court trial the attorneys for the disputants present their cases, witnesses are heard, documents reviewed, and then a decision is rendered. This decision customarily is confirmed, upon petition of the winning party, by the local Superior Court.

A substantial advantage for the plaintiff is the admissibility of hearsay evidence.[4] Thus, textbook evidence may be introduced. A transcript of the proceeding is not required unless one of the parties demands it. And the informality of the proceeding is further evidenced by CCP Section 1282.2, Paragraph (g) which permits the neutral arbitrator "to base an award upon information not obtained at the hearing" only providing "he shall disclose such information to all parties to the arbitration and give the parties an opportunity to meet it." Even an oath is not required of witnesses unless requested by a party.

Achieving arbitration pursuant to the contract follows notification of the defendant by the plaintiff's attorney. At Ross-Loos a three-man arbitration panel is used. That is, each side chooses an arbitrator and they must agree on the neutral arbitrator. The arbitration agreement states that fifteen days are allowed for the selection of the parties' arbitrators and then the neutral arbitrator must be selected, and the arbitration held, within a "reasonable time."

Is the arbitration contract legal? The California Supreme Court has answered this question emphatically. In *Doyle vs. Giuliucci*[5] the court stated that an arbitration agreement "does no more than specifiy a forum for settlement of disputes." With this phrase the whole question of deprivation of some fundamental right is dismissed. In other words, it is the party's right to pursue litigation in *some* forum rather than in a particular forum, which is constitutionally protected. It is commonly thought that the limited scope of appeal amounts to a denial of rights. But the California Supreme Court in the Doyle decision noted that there exists a right to appeal and let it go at that.[6] The grounds for appeal, however, are extremely limited.

Another California Supreme Court decision illustrates the court's partiality to arbitration. In *Morris vs. Zuckerman*[7] the party who lost in the arbitration proceeding appealed, contending that the arbitration contract did not anticipate the sort of issues which were involved in the particular dispute and therefore the proceeding should have taken place in a civil court. The Supreme Court ruled that whether the facts placed the case within the arbitration contract was solely a matter for the arbitrators to decide. "Any doubt as to the meaning or extent of an arbitration agreement must be resolved by the arbitrators and not by a reviewing court." And, "In arbitration proceedings it is for the arbitrators and not the courts to determine which issues are 'necessary' . . . .to determine the controversy . . . ."

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[3] California Code of Civil Procedure Section 1281.6 states, "If the arbitration agreement provides a method of appointing an arbitrator, such method shall be followed. If the arbitration agreement does not provide a method for appointing an arbitrator, the parties to the agreement who seek arbitration and against whom arbitration is sought may agree on a method of appointing an arbitrator and that method shall be followed. In the absence of an agreed method, or if the agreed method fails or for any reason cannot be followed. . . .the court, on petition of a party to the arbitration agreement, shall appoint the arbitrator.

When a petition is made to the court to appoint a neutral arbitrator, the court shall nominate five persons from lists of persons supplied jointed by the parties to the arbitration or obtained from a governmental agency concerned with arbitration or private disinterested association concerned with arbitration. The parties to the agreement who seek arbitration and against whom arbitration is sought may within five days of receipt of notice of such nominees from the court jointly select the arbitrator whether or not such arbitrators are among the nominees. If such parties fail to select an arbitrator within the five-day period, the court shall appoint the arbitrator from the nominees." Thus, the mechanism exists for rapid resolution of what turns out to be the most difficult feature in accomplishing a malpractice arbitration, that is the selection of a neutral arbitrator. It seems clear that if a group of unbiased and competent neutral arbitrators could be developed in a community, a potential stumbling block for this alternative to courtroom litigation would be climinated.

[4] California Code of Civil Procedure, Section 1282.2 (d) states, "The parties to the arbitration are entitled to be heard, to present evidence and to cross examine witncsses appearing at the hearing, but rules of evidence and rules of judicial procedure need not be observed. . . ."

[5] 62 Cal. 2d 606 (1965).

[6] The Court stated, "[B] oth the issue of arbitrability and the award are subject to judicial review." Of course, the party has the right to contend that the arbitration contract is invalid. If the Superior Court turns down such a petition, appeal is available through the usual route. But the scope of appeal is very narrow. Following arbitration the Superior Court may vacate the arbitrators' award "if the Court determines that:

> (a) the award was procured by corruption, fraud or other undue means;
>
> (b) there was corruption in any of the arbitrators;
>
> "(c) the rights of such party were substantially prejudiced by the misconduct of a neutral arbitrator;
>
> (d) the arbitrators exceeded their powers and the award cannot be corrected without affecting the merits of the decision upon the controversy submitted; or
>
> (e) the rights of such party were substantially prejudiced by the refusal of the arbitrators to postpone the hearing upon sufficient cause being shown therefor or by the refusal of the arbitrators to hear evidence material to the controversy or by other conduct of the arbitrators contrary to the provisions of this title."

This sharply limited scope of appeal makes arbitration efficient, and for the physician, whether he wins or loses, it at least provides finality. Especially for a physician the protracted course of customary litigation may be an enormous burden. In San Francisco a trial was recently held for the third time, the course of litigation having extended over a period of several years.

The arbitration contract, however, does not enjoy a privileged position when viewed by the laws of contracts. CCP Section 1280 specifically states that the contract is enforceable "save upon such grounds as exist at law or in equity for the revocation of any contract. . . " For example, in the recent case of *Windsor Mills Inc. vs. Collins and Aikman Corp.*[8] a purchaser of goods sent with his order to the seller an "acknowledgement of order" form. The seller filled this out without being aware of the fact that, in small print, an arbitration clause was included in the writing. A California District Court of Appeal ruled that the seller was not bound by the arbitration contract which was inconspicuous, of which he was unaware, "and which was contained in a document whose contractual nature was not obvious."

There is an opportunity for an adhesion contract when the patient signs the arbitration agreement. Adhesion occurs where a party in an inferior bargaining position is forced to sign a contract or forego an urgently needed service from one who is in a superior bargaining position. So the patient who signed the agreement while he was acutely ill probably would be on solid ground if he later sought to void the contract, asserting that he *felt* he had to sign or forego the needed treatment.[9]

In 1970 Section 1283.05 was added to California arbitration statutes. This provides for discovery as in any civil proceeding. The "arbitrator or arbitrators themselves shall have power in addition to the power of determining the merits of the arbitration, to enforce the right, remedies, procedures, duties, liabilities and obligations of discovery by the imposition of the same terms, conditions, consequences, liabilities, sanctions and penalties as can be or may be imposed in like circumstances in a civil action by a Superior Court. . . .except the power to order the arrest or imprisonment of a person."

Analysis of 35 Closed Cases

The fairness of arbitration is a major concern underlying this study. Whether a case is settled or arbitrated the reasonableness of the outcome can be analyzed from three points of view: First, was a settlement before arbitration prompted by existence of the arbitration agreement? There is no doubt that courtroom litigation constitutes a formidable barrier for the plaintiff with a small case. It is simply not worthwhile for the skillful plaintiff's malpractice attorney to pursue a case worth only a few thousand dollars.[10] Because small cases usually present almost as difficult analytical and trial problems as big ones, it is common to find the general practice attorney losing such cases. (It is no secret that malpractice carriers take into account the quality of the attorney in deciding whether to settle a case or try it.) Once burned a couple of times, the non-specialist probably will avoid the malpractice case which he cannot refer to a specialist. It is likely, then, that the plaintiff with a valid but small case will wind up with no attorney at all or with one who is not sufficiently skilled to win. Arbitration, however, changes the equation. In arbitration the plaintiff's attorney can use textbook evidence and so his need for a medical expert is not crucial. The competent neutral arbitrator probably will be more accurate in his evaluation of liability issues, and so the plaintiff's attorney who lacks rhetorical skill, finesse in organizing and presenting his case, still has a good chance to win. In terms of time spent at a hearing, compared with the time required for a trial, arbitration is very economical for the plaintiff's attorney.

With these factors in mind, the 35 closed cases described in the following pages reveal a significant number of small cases which were settled by the Ross-Loos administration but which, in the absence of arbitration, a malpractice carrier may well not have agreed to settle, even though the cases seemed to offer the plaintiff's attorney a good shot at liability. That is, from a strictly legal point of view it seems just that the patient received indemnity, yet without arbitration it is unlikely recovery would have been obtained.

Another group of small cases among the 35 discussed below might be regarded as "nuisance" claims, or as attempts to deal in an enlightened and considerate manner with patients who sincerely believed they have suffered some medical injury but whose cases appear to have little legal merit. Fairness in this context is outside the legalistic frame of reference. The existence of arbitration, however, is highly relevant to these cases. It may attract the non-specialist to a case which, because of the combination of modest injury and slim liability, he would not consider for conventional litigation. In essence, the economy of arbitration may make a "nuisance" case more of a nuisance. One must add that, if this is true, there is still no plethora of cases which have descended on Ross-Loos or the others who employ binding arbitration.

A third group of cases among the 35 case studies are the three that have actually been arbitrated since 1964. The result of one of these cases appears to be reasonable; a court trial probably would have yielded a similar outcome. In the two other cases, however, a jury very likely would have found for the plaintiff, although the arbitrators' decision for the defendant was probably fair, in this author's view.

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[7] 60 Cal. 2d 686 (1968).

[8] 25 Cal. App. 3d 987 (1972).

[9] This is to be differentiated from the type of contract in *Tunkl vs. Regents of the University of California* where the patient signed an agreement not to sue his physician. The California Supreme Court held this contract void because it was contrary to public policy. 60 Cal. 2d 96 (1963).

[10] One prominent California malpractice specialist told this author he would not accept a case, even with open and shut liability, which was worth less than $25,000. Another said that his break point was $50,000. Generally speaking, it is just as likely that a small case will present complex medical facts and be as difficult to work up and try as a big one. So little cases are just not worth the time of the busy malpractice specialist.

In addition to the 35 cases discussed below, there are 36 claims which have been filed since 1966 in Superior Court and then stayed, either through court order or by stipulation. Following this defense maneuver, 23 of these cases simply disappeared. That is, the plaintiffs' attorneys did not pursue them. Naturally, no review of these cases was possible since any comment might stimulate legal activity and thus incur defense expenses. One may note, however, that the apparent abandonment of these cases is puzzling. What is there about arbitration that made these attorneys "roll over and play dead?" Others involved with binding arbitration have noted the same tendency. The following analysis was suggested to me by an experienced attorney.

The skillful attorney's frame of reference is not limited to courtroom activity which stresses techniques of persuasion that may touch only lightly on fact issues. He also must be exceptionally competent in developing in depth the facts of his case. But there are a number of attorneys who have become skillful at persuasion and yet have never developed the art of fact analysis, especially in medical malpractice cases. Ideally, in arbitration fact analysis and persuasion would be coterminous. To the extent that such an attorney perceives this, and feels that this would be a substantial change from the demands made on him in a jury trial, he would be likely to drop a case which had to be arbitrated.

In my analysis the cases have been numbered in order to provide anonymity for the patients. Attorneys were involved in case 1–21. No attorneys were involved in cases 22–35. Only the first three cases discussed actually reached the formal arbitration stage. Cases 4-35 were settled by negotiation before any formal proceedings took place.

CASES WHERE COUNSEL WAS INVOLVED

Case No. 1:

This arbitration resulted in a $70,000 judgment. The patient was a heavy drinker who presented a history of repeated nose bleeds for several years, high blood pressure, obesity, and arteriosclerotic cardiovascular disease. He was 52 years old at the time of his death.

He came to the Ross-Loos outpatient clinic on the morning of April 3, 1962 complaining of a nasal hemorrhage which had begun a couple of hours earlier. At that time his nose was packed and he was sent home. He returned within a few hours because of persistent bleeding and was admitted to the hospital. Despite packing the bleeding persisted, requiring a pint of blood on April 5, another on April 6 and one on April 7. Five units were given on April 8 and two on April 9. His clotting mechanism was normal, so this was a local problem.

The patient's course was complicated from the beginning. Bleeding continued intermittently despite the nasal packing. The hemoglobin varied from 12 grams on April 2 to 5.6 grams on April 8. The packed cell volume fell as low as 18. The medical progress notes identify the fact that this was an unusual problem of epistaxis.

On April 5 a progress note stated, "Nose bleeding continued from right anterior ethemoidal artery and sphenopalatine artery posterolaterally. Hemoglobin down to 6.7 grams." On the 8th, "Bleeding from posterior part of nose and nasopharynx continues, right. Blood transfusion but hemoglobin still dropping." And later that day, "Profuse sweating, hysterical. Blood Pressure 180/100. Severe dyspnea, pallor gagging, grossly swollen soft palate, uvula, patient choking himself." He was sedated and shortly thereafter he was "much improved."

Early on April 9 it was noted the patient was still bleeding. Later on that day he was said to be "semi-narcotized." After commenting on the fact that there was no "major bleeding" the doctor recommended continuation of conservative treatment.

On the afternoon of April 10 the patient's soft palate was noted to be very edematous. A nasopharyngeal airway was in place through which he was receiving oxygen. Later on that day the patient was described as "markedly agitated, color good, some stridor." His heart rate was 116 and his blood pressure 180/100. His physician felt he was experiencing D.T.'s, and he was concerned that he might be manifesting early heart failure. (The plaintiff's attorney asserted that the patient's critical status secondary to the nasal hemorrhage was confused with symptoms relating to D.T.'s.)

On April 11, just before midnight: "Patient seen this p.m. because of drop in blood pressure. Patient unconscious and cyanotic and in oxygen tent. Dark foamy fluid coming from the mouth, emergency tracheostomy without anesthesia. Large amount of dark fluid in trachea aspirated and patient given cardiac massage and oxygen." Shortly thereafter he was pronounced dead.

The nurses' notes indicate that on April 11 his blood pressure dropped to 118/80 at 8:00 a.m. and his abdomen was quite distended at 11:00 a.m. An at 4:15 p.m. his blood pressure was 110/82, at 11:00 p.m. 108/74. At 11:30 p.m. it was 106/80. The nurse wrote that he was "constantly expectorating large amounts of coffee ground emesis."

The autopsy indicated death was due to aspiration of this material. The plaintiff contended at the hearing that a nasogastric tube would have obviated this risk. Further, he stated that there was neglect of the patient during the 18 hours or so prior to his death.

The autopsy also revealed multiple acute gastric ulcers with erosion into blood vessels, so that patient must have been bleeding from these areas. Early on the 11th his hemoglobin was 13 grams. Had this bleeding become severe after the hemoglobin was drawn, so that death was in part due to exsanguination? The blood pressures would be consistent with that theory.

The plaintiff presented an expert witness at the hearing. He contended that the patient had exsanguinated and that the terminal event was aspiration of blood. He said the nasogastric intubation would not only have prevented aspiration but would have early identified the gastric bleeding. He felt also that a tracheostomy should have been performed in order to provide a more adequate airway. But the failure to use a nasogastric tube was claimed to be the more serious oversight.

It was the defense theory that the patient had suffered D.T.'s and death was somehow related to that. However, this line of argument was not strong.

The arbitration consumed 7 1/2 days. The case was not arbitrated in continuity, the hearings being held on October 31, 1964, January 9, May 22 and 23, and June 5, 6, and 26, 1965. Additional arbitration took place on August 24 and 25 for 2 1/2 hours each day.

> COMMENT: This was a case of liability which, even in 1964, almost certainly would have been won before a jury. The medical testimony was complex and voluminous. It is doubtful that a jury trial would have consumed less than three or four weeks.

The plaintiff's attorney, the defense attorney, the neutral arbitrator, and the plaintiff's arbitrator were interviewed about the case. The plaintiff's attorney said he believed that the award was "the right amount," and he felt a jury at that time would have given him about the same. The extension of the arbitration over a period of time was inconvenient for him, and he felt that he lost a certain continuity in his presentation. However, he said the neutral arbitrator was extremely good. As other attorneys have repeatedly stressed in this study, the expertise and fairness of the neutral arbitrator is crucial. The attorney felt that the arbitrator he selected, a physician-attorney, was important to his case. This arbitrator served to clarify some of the more difficult issues.

The attorney said he favored arbitration in small cases, regardless of venue, and he felt that arbitration even in major cases would be preferable in rural counties because there the juries tend to favor the physician, and the availability of textbook evidence might be crucial because it is more difficult to obtain medical experts in these counties. However, in metropolitan areas he would much rather take a major case before a jury. He felt the chances for a high award were better and he felt juries might be less critical of the plaintiff's position in a case of somewhat equivocal liability where injuries were grave.

The defense attorney felt that this case was a loser and he said the value was approximately right. He felt the neutral arbitrator was excellent.

The neutral arbitrator indicated the case went smoothly and efficiently. He felt the "cast of characters was good"; i.e., the attorneys. He likes arbitration as a procedural device, providing one can find a competent neutral arbitrator. He said this would not have to be a personal injury specialist. He, himself, had done almost no personal injury work, yet he felt he had no difficulty in comprehending the medical facts. Similarly, he felt that familiarity with medicine was not a necessity. But he did feel the neutral arbitrator should be a trial lawyer, because such individuals are accustomed to absorbing new knowledge.

The plaintiff's arbitrator, a physician-attorney and malpractice plaintiff's specialist, is strongly opposed to arbitration. He was the plaintiff's attorney in two other cases in this study. He said he settles 90% of his own cases so, "I am the arbitrator." He pointed out that in metropolitan areas there has been a striking increase in the availability of plaintiff's expert witnesses during the past few years, and he felt this greatly facilitated the settlement of cases. He felt the value of the case at hand, before a jury, would have been $125,000. He also criticized the long period of time over which the arbitration extended and blamed this on the absence of a single coercive force, either a judge or a judicial rule.

The arbitrator selected by the defense was deceased. With regard to costs, the defense attorney's fees came to $1,575 and the arbitrators' fees were billed at $200 per day, with each 2 1/2 hour day being billed at $62.50. (Each side paid this amount.) These represent the total expenses in the case, since there were no costs for investigation, the services of a reporter, etc. The preparation of this type of case for usual litigation plus the expenses of a jury trial would cost several times as much.

Case No. 2:

This arbitration ended in a defense verdict in February 1971. The patient, age 59, was admitted to the hospital on November 22, 1967 complaining of severe headaches for four days. He had struck his head on a steel door two months earlier, suffering a scalp laceration and momentary loss of consciousness. He was examined at that time but no treatment was given and he returned to work.

Physical examination on hospital admission was essentially normal. A brain scan on the 24th was abnormal however, and three days later a right carotid arteriogram revealed "an avascular area" present in the posterior occipital region. This was "suggestive of space-occupying process."

On November 29 the patient was found lying on the floor of the hospital room with a small laceration on the bridge of his nose. It was then that a spinal tap was done which revealed a large number of white cells. A strain of the spinal fluid identified Gram negative rods. Early the next morning the patient suddenly lost consciousness. A tracheostomy was performed and at 1:30 p.m. on November 30 a craniotomy was done and a brain abscess drained. The patient died on December 1.

The coroner's examination identified an abscess in the right parietal-occipital region, located beneath the point of impact of his head injury two months earlier.

In the course of the arbitration of the case, there were experts for both sides, but the plaintiff's expert a neurosurgeon, appeared only through affidavit. He was very critical of the management of the case, stating that it had been handled in a substandard manner and that "this patient never had adequate care, neither after his brain concussion nor later when remained in the hospital from November 22 to November 30 at which time he lapsed into a fatal coma . . ."

Observers at the arbitration felt that the most crucial witness was the neurosurgeon who appeared for the defense. He stressed the causation issue, asserting that by the time there was clearcut evidence calling for surgical intervention the fatal outcome probably was inevitable.

> COMMENT: This case almost certainly would have been won before a jury. As indicated below, the neutral arbitrator would not offer any discussion concerning the case itself; thus I can't be sure that the causation question was crucial for him. But assuming this was the case, juries are notoriously unwilling to find for the defense on the narrow causation question when they feel there has been negligent management. The plaintiff's attorney, naturally, felt the jury would have decided in his favor. The defense felt that the causation argument was a strong one. If that is the case, then fairness was served by arbitration.

The plaintiff's attorney told this author that he felt he would have won, but for the last witness. He said the case was mainly lost on the causation question. He felt strongly that diagnostic tests, especially a spinal tap, should have been performed sooner.

With regard to the general question of arbitration, the plaintiff's attorney felt that it had some good possibilities. He said juries tend to favor physicians in equivocal cases and one might obtain a more objective evaluation on such marginal questions from an arbitrator. Remarkably, he was concerned about "the problem of defamation" for the physician in a public trial. He said that arbitration would be valuable in taking the physician's difficult experience away from the public eye. He recommended a single arbitrator for the sake of economy, and pointed out that both sides could just as easily agree on a neutral arbitrator without introducing the second and third arbitrators. He said arbitration could be speedy, providing each side was diligent in pursuing pre-hearing preparation and in following through with the hearing itself.

As others have commented, he felt arbitration would be excellent for rural counties both with regard to liability and damages, since the objective arbitrator probably would prove more fair than a rural jury. He said that arbitration, although a good idea, should not be the "exclusive forum."

The neutral arbitrator, a former judge, refused to comment on this case. In general, he felt that arbitration of medical malpractice could be a "good medium." He also indicated that a single arbitrator is preferable. He said that retired judges, who had demonstrated their neutrality, would make a good resevoir of arbitrators. He stressed the importance of finding fair-minded and competent neutral arbitrators.

The arbitrator for the plaintiff asserted that a jury almost certainly would have decided for the patient. He emphasized the importance of the defense medical witness, who testified at the end of the hearing. He felt the privacy of arbitration has an adverse social effect, and he indicated that, should malpractice arbitration become popular, there must be some way of reporting all decisions.

The arbitrator for the defense felt that the neutral arbitrator was notably fair and indicated that the case went smoothly.

This case used up 3½ days in arbitration. It is unlikely that a case of this complexity could be tried before a jury in less than three weeks.

The total cost for the defense was slightly under $3,000. Again, this is a total cost, including attorney fees, depositions and discoveries, as well as the arbitration proceeding itself. As with the previous case, the evaluation and jury trial for this type of case would cost several times this amount.

Case No. 3:

This is the famous case of *Doyle vs. Giuliucci.*[11] Dr. *Giuliucci* was a physician at Ross-Loos Medical Group. The arbitration produced a defense verdict on September 10, 1962. The result of the appeal and the court's reasoning were analyzed above.

The medical facts clearly point to an absence of liability. In June 1960, at the age of 3 years, the patient was seen at a Ross-Loos office in Pomona for recurrent vomiting. Thorazine suppositories, 25 mgs twice a day, were prescribed. The patient used about 25 suppositories: At about the same time the patient developed a skin eruption on her abdomen. This lasted three or four days. On July 14 she entered the hospital because of headaches, somnolence, unsteady gait, frequent vomiting, poor balance, etc. The neurological degeneration had been proceding for about three weeks. Encephalitis was the prime diagnostic guess with brain tumor a close second.

The patient partially recovered from this acute illness, and no definite etiology was ever decided upon. The final diagnostic impression was encephalitis. She was left with slurred speech and some ataxia. In December 1960 there was speculation that the entire problem might have been a toxic reaction from Thorazine, although the total dose per 24 hours did not exceed the maximum of 2 mgs per pound of body weight. The neurologist who evaluated the patient felt that she was suffering from a postencephalitis syndrome. One of them pointed to the skin rash in June as indicative of a virus infection.

> COMMENT: In 1962 this case probably would have been won before a jury. It is very doubtful if there was any liability.

In an interview plaintiff's attorney stated he had a very poor recollection of the case. He said he had no philosophical objection to arbitration, but would prefer a single arbitrator to a three-man panel.

The defense attorney felt the arbitration was very fair. Both he and the plaintiff's attorney regarded the neutral arbitrator as extremely objective.

The neutral arbitrator has been a professor of torts at U.C.L.A School of Law for many years. He told me that the crucial point in successful malpractice arbitration is the obtaining of an objective and skilled arbitrator. He said such a man should have experience in personal injury trial work, although he did not feel that particular sophistication in medicine was necessary. He felt an arbitrator would be far more capable of absorbing complex medical testimony than a jury.

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[11] 62 Cal. 2d 606 (1965).

Case No. 4: Settlement for $80,000 on March 31, 1971.

A claimant, a 41-year old woman, was subjected to low back surgery for a herniated lumbar disc on June 20, 1967. About 14 hours following surgery she went into shock and, after repeated transfusions, re-operation revealed a "massive retroperitoneal hemorrhage." There were penetrations of both the right common iliac artery and vein. The artery was grafted, but shock was irreversible and the patient died on the evening of June 21.

> COMMENT: This case probably was not defensible. If is sometimes stated that vascular injury incident to lumbar disc surgery is a calculated risk of the procedure, but such cases usually involve older patients who have friable tissues.

The patient's attorney told this author that the settlement was "top fair dollar," and this would be true if it had been headed for courtroom litigation. Nevertheless, it is his opinion that damages awarded by an arbitrator are likely to be less than those awarded by a jury, and that ordinarily this tends to promote settlement where liability exists. He specifically noted that part of the skillful attorney's jury technique for getting "adequate" damages is to stir up a jury's feelings about the patient's pain and suffering, etc. Another important technique, he said, is to make the jury angry at the defendant-physician. He felt the objective arbitrator would be much less susceptible to these rhetorical devices.

He made an interesting observation which was echoed by only one other attorney: Arbitration provides a significant advantage to the plaintiff where his attorney is not especially expert. This is because the skillful arbitrator could legitimately undertake questioning and evaluation of the case (reviewing records, etc.) to a far greater extent than could a judge in a jury trial. He also observed that in smaller counties arbitration would be a great advantage to the plaintiff, because of the greater objectivity of an arbitrator.

This particular case was of special interest because the Superior Court judge ruled that arbitration could not be permitted, since it was the husband who had signed the arbitration contract rather than the deceased wife. This is similar to the Doyle situation. The plaintiff's attorney felt that if the case had been appealed all the way to the California Supreme Court the Doyle logic would have been applied. The defense felt there was no point in letting the case drag on, since it probably would be lost if it was ultimately arbitrated.[12]

Case No. 5: Settlement for $9,000 on April 23, 1968.

In late 1966 the claimant, a 52-year old man, presented a history of difficulty with swallowing for three months. He said food would stick in his throat. He had no other complaints. Esophageal films and evaluation of the swallowing mechanism in December 1966 were negative. A chest film in January 1967 and esophogoscopy on January 11 were both normal. The esophogoscopist noted that the "folds of mucous appear hypertrophied, smooth and uniform in texture. I see no reason for a biopsy."

The patient's son was a medical student at U.C.L.A. Medical Center; so a few weeks after the esophogoscopy the patient went there for evaluation by an ENT specialist. This physician identified an early cancer of the vocal cord.

Although it was by no means clear that this lesion actually was causing the trouble with swallowing, the case was settled. The plaintiff allegedly was ready to prove that the lesion should have been discernible upon initial evaluation at the Ross-Loos Clinic.

> COMMENT: This is the only significant case where the plaintiff's attorney was not available for interview.

Case No. 6: Settlement for $32,175 on February 21, 1967.

In October 1955 the claimant entered the hospital for surgical treatment of his ulcerative colitis. Initially there was a subtotal colectomy, but shortly after hospital discharge the patient began to hemorrhage from his bowel and returned for removal of more of his colon. At that time he had an ileostomy. This was followed by yet another hemorrhage and a complete colectomy was necessary. On the occasion of that surgery the physician accidentally severed the prostatic urethra.

The urethra was immediately repaired and a Foley catheter installed. The catheter was kept in place for about three months with weekly changes. Local infection became a problem and ultimately a suprapubic catheter was installed. A perineal sinus had developed due to the infection, and soon thereafter the patient passed a fragment of a catheter. Thus, this foreign body either accounted for the infection in the first place or perpetuated it. The plaintiff was ready to assert that there was negligence both in injury to the urethra and in leaving the foreign body behind.

> COMMENT: Although it is not clear that severing of the prostatic urethra in the course of difficult surgery is necessarily negligent, this is a clear liability case because of the foreign

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[12] Even without the Doyle precedent, it would be easy to argue that since a wrongful death action vests a right in the survivor, and the husband was bound by an arbitration agreement, he had a contractual obligation to arbitrate the case. But what of the situation where the decedent signed the arbitration contract but the survivor had not, and was not even receiving care in the Clinic? Is it logical to require arbitration in that situation? The survivor could argue that the wrongful death action belongs to him, and so the patient's contract is irrelevant to that right.

> body. The settlement is substantial for 1967 and it is doubtful there would have been a better settlement if the case were proceeding to conventional litigation.

The plaintiff's attorney informed me that the patient had made an excellent recovery and that there was a certain statute of limitations problem which might have surfaced in the case. This made him all the more willing to settle. He feels a philosophical opposition to arbitration, believing that the jury system, "tested for centuries," is always preferable to any alternative.

Case No. 7: Settlement for $65,000 on November 8, 1966.

The claimant, a middle-aged man, injured his back in 1955 and was subjected to low back surgery on March 8, 1956. Spinal anesthesia consisted of 10 mgs of Pontocaine. He awoke to discover that both his legs were paralyzed and lacked sensation, and he had no bladder or bowel control. Initially, there was an area of numbness which extended to his waist. Over the next few years, this condition improved to the point that he could walk with braces and he had regained sphincter control. But he was unable to use the right leg from the knee down and could move his left foot only weakly.

There was disagreement concerning the etiology of the problem. One neurologist felt there was an hysterical component but he also conceded there must be organic damage. The case was particularly peculiar because there was a history of a spinal anesthesia in 1949, for urological surgery, and the patient had a similar paralysis which lasted for one or two weeks, but then he recovered completely. The final diagnosis was "tranverse myelitis or myelopathy, level L-1, and downward, etiology unknown, complicated by paralysis of lower extremities, incontinent. . . ."

> COMMENT: Transverse myelitis, is an intrinsic risk of spinal anesthesia. However, the California Supreme Court in *Seneris vs. Haas*[13] ruled that such an injury following spinal anesthetic raises an inference of negligence which the doctor-defendant must rebut. The impact of this decision has been considerably reduced by subsequent California Supreme Court decisions, yet it still carries weight. It is my guess that this is the type of case which might well be lost by the plaintiff in arbitration, where the calculated risk of transverse myelitis might be made clear to the neutral arbitrator. Of course, given the history of a spinal anesthesia and similar problem several years earlier, it is questionable whether the doctors should reasonably have discovered this fact and then withheld the anesthetic modality. Before a jury, a case like this quite likely would have been won in 1966.

The plaintiff's attorney told me that this case was settled just before arbitration. He also stated that the patient ultimately recovered almost completely, so this is further evidence that it was indeed a transverse myelitis. He felt he received maximum value for the case, and that he would not have obtained a better settlement if a jury trial were anticipated.

The plaintiff's attorney said he is very partial to the arbitration concept in malpractice cases, because he lacks confidence in the jury's skill to analyze complex medical facts. However, he added that the value of the arbitrator is purely dependent upon his skill and knowledge. Providing he could obtain such an arbitrator, he would "prefer arbitration any day." The attorney added that he made these remarks in the context of several decades of law practice with emphasis on personal injury work.

Case No. 8: Settlement for $17,500 on November 9, 1964.

This case was settled on the day arbitration was to begin. The 53-year old patient visited Ross-Loos clinic on June 4, 1960, complaining of pain in her right heel. She indicated that a similar problem ten years earlier had been diagnosed as bursitis and successfully treated with a single injection into the area. She felt her problem was due to standing on a cement floor at work all day.

The patient was given an injection of cortisone into the heel and this made her cry out. She said the doctor told her, "We must have hit the bone." The area immediately became numb and remained that way for two days. When she tried to stand on the heel, it was so sore she could not bear weight.

When the patient returned to the clinic several days later, the heel was swollen and inflamed. Within a matter of weeks an X-ray demonstrated osteomyelitis in the area. This required four subsequent hospitalizations and repeated debridement. At the time of arbitration, the patient had a chronic osteomyelitis with two draining sinuses and she had been in a wheel chair for about one year and on crutches for another three years. She complained of constant pain in the area. She weighed 260 lbs. and this complicated her treatment.

> COMMENT: In 1964 case values were far less than they are at the present time. Today the fact that the case was worth more than $17,500 just in wage loss and medical treatments alone probably would have dictated either a larger settlement or pursuit of the case through arbitration. The liability issue is not completely clearcut. However, it seems virtually certain that the needle struck the calcaneus, an accident which probably is not within the risk of this procedure. Did that have anything to do with the development of infection? This is the speculative part of the case. Before a jury, the case almost certainly would have been

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[13] 45 Cal. 2d 811 (1955).

> won. In arbitration the plaintiff probably would have had the edge as well.

In an interview, the plaintiff's attorney said he had some reservations about the negligence issue in the case and that this is why he settled. It is interesting that the defense and plaintiff could not agree on a neutral arbitrator, and so the plaintiff's attorney petitioned the Superior Court judge to assign one.

The attorney felt that arbitration tends to keep settlement somewhat low because arbitrators are more "emotionless" than a jury would be, thus benefiting the defense. On the other hand, he emphasized that the ability of an arbitrator to deal with complex facts made arbitration preferable in complex cases where liability is present but not obvious. However, he preferred jury trial in a case of clearcut liability because a jury can get "worked up," especially in cases of severe injury.

Case No. 9: Settlement for $10,000 on June 27, 1967.

The claimant, 13-year old girl, entered the hospital on December 29, 1957 with a fractured right femur. An intramedullary nail was placed two days later.

While in the hospital she did well for a couple of weeks and then gradually experienced increasing pain in the thigh plus tenderness. On February 28, 1958, after she had been discharged, she developed a fever of 101 and redness appeared at the lower end of the operative scar. But her white count was normal. On March 3, because of persistent fever, she was admitted to the hospital.

At this time an abscess was identified and drained. She was treated intensively with antibiotics. The infection was controlled at first but then recurred repeatedly, requiring several subsequent hospitalizations for repeated drainage and debridement. There was marked residual scarring and the patient limped.

> COMMENT: Postoperative infection in orthopedic cases does not automatically raise a negligence issue, and these cases are seldom won by the plaintiff unless there is an associated failure to recognize early evidence of the infection and deal with it appropriately. The medical records were not sufficiently detailed to permit a reliable estimate about the timeliness of recognition of the complication.

The plaintiff's attorney felt that the settlement was somewhat low. He said the case was "stale," nine years having elapsed between the episode and settlement. He stated the limp was much less prominent by the time the case was settled, so the main disability was cosmetic.

This attorney favors arbitration in small cases, but he prefers a single arbitrator. And in rural counties he favors arbitration even in big cases, feeling the arbitrator would be more objective than a rural jury. He was emphatic about the need for an expert and unbiased neutral arbitrator.

Case No. 10: Settlement for $12,500 in July 1965.

This is a case of unusual complexity where there was probably no malpractice, but the case could have been lost in an arbitration. It was settled just before arbitration was to begin.

The case involved a diagnostic problem. The patient, 46 years old, was hospitalized in December 1960 for evaluation of fairly typical angina pectoris. Several EKG's demonstrated changes resembling the early phases of acute myocardial infarction, but reversion toward normal before the fully developed infarction pattern was manifested. Serum enzymes were normal and there was only a slightly elevated sedimentation rate. A diagnosis of acute coronary insufficiency without infarction seems the logical one from these EKG changes.

The patient returned to the hospital four weeks later with almost identical complaints. Again a series of EKG's demonstrated a fluctuating change which ultimately disappeared. At no time did the EKG or enzyme studies identify an infarction. So again, this is consistent with a diagnosis of acute coronary insufficiency.

In between the two hospitalizations a diagnosis of mild diabetes was made. The patient was placed on oral anti-diabetic drugs because he did not wish to take insulin.

The patient lived in Pasadena, and the physician who had treated him during his hospitalization assumed he would be followed at the Pasadena office. But the patient was unwilling to be treated by anyone else, so his Los Angeles internist prescribed anticoagulant therapy by telephone, the periodic studies being done at the Pasadena office. On April 20 when the internist examined the patient, he noted there was no chest pain or shortness of breath although the patient complained of being tired. The EKG changes were consistent with ischemia. The patient was working, the physician having told him after the second hospitalization that he could return to work.

The patient traveled to the Los Angeles Ross-Loos eye clinic four times from March 17 to April 6, but he did not see his internist on these visits. Thus, presumably he was doing relatively well. He had experienced no chest pains since the episode which brought him to the hospital in January. Then he died suddenly at his home on October 10, 1961.

The major problem for the defense was the opinion of a cardiologist in Pasadena. He had examined the patient on April 28, 1961 at which time he complained of fatigue and weakness. The patient was placed in a Pasadena hospital and an X-ray demonstrated some congestion of the right lower lung. This was interpreted as secondary to heart failure. No infarction was demonstrated on repeat EKG's. This cardiologist assumed the patient had experienced an infarction either in December or January, and he was critical that he had not been maintained at bedrest for a longer period of time and also that his physician had permitted him to return to work. He felt that at least the patient should have had a more careful followup and supervision after release from the hospital. He stated in a letter to the plaintiff's attorney that the patient's prognosis for life was five to ten years of "useful activity" if he had been appropriately managed. It is interesting that he saw the patient in his office on September 5, 1961 and told him he could return to work on September 11. It was less than a month later that he dropped dead.

> COMMENT: This case was settled mainly because of the cardiologist's opinion. The defense would argue that there was no nexus between the failure of supervision and the patient's sudden death, especially in view of the two earlier episodes of acute coronary insufficiency. Such patients presumably are gradually developing critical attrition in coronary circulation and so the handwriting is on the wall. I feel this was a case of no liability, but one which might have been won by the plaintiff, either in arbitration or jury trial, considering the medical support the plaintiff's attorney would receive.

The plaintiff's attorney agreed with me that the case was medically very complex and he thought there might be no liability. He felt, in view of this, the value of the case was about right in 1965.

This is the same attorney who was involved in case No. 9, and his general attitude toward arbitration was noted there.

Case No. 11: Settlement for $3,500 on January 16, 1970.

On December 6, 1968 the claimant, a 42-year old police officer, was subjected to surgery for removal of a callus on the sole of the right foot. For 15 years he had been treated off and on for this persistent lesion. The consequence of this surgery was a painful foot. A second surgery by an orthopedist was necessary to relieve the pain.

The patient sued the first physician, asserting that the surgical attack was incorrect. He said the approach should have been through the dorsum of the foot. He had seen two orthopedists for treatment who were ready to testify for him on that issue.

> COMMENT: Assuming the patient's orthopedist would have testified against the Ross-Loos physician, this was a case of liability. The settlement value was about right.

The plaintiff's attorney said that this is the type of case which is ideal for arbitration. He felt it was too small to justify the expense of courtroom litigation. He was not especially familiar with arbitration and was unaware that textbook evidence would be admissible there. He preferred jury trials for large cases.

Case No. 12: Settlement for $6,750 on September 14, 1964.

On June 2, 1962 the patient was seen on a house call by a Ross-Loos physician for an "acute anxiety attack." She had been seen previously at the clinic for episodes of nausea and abdominal pain. On January 4, 1962 a gall bladder X-ray was normal. On August 16, 1962 an upper G.I. series revealed "an antral gastritis with prolapse of gastric mucosa into the base of the duodenal bulb."

Shortly thereafter the patient was hospitalized by an outside physician. In a letter to the defense attorney the plaintiff's attorney stated, "X-rays were then taken and the trouble was quickly diagnosed by the roentgenologist as a straight pin in and through the stomach wall. . . ." Surgery removed the pin and the patient did well thereafter. Upon reviewing the previous X-rays the straight pin was apparent, so it had simply been overlooked.

> COMMENT: This is a clear liability case, and one which ordinarily would be settled by any malpractice carrier even without the intervention of an attorney.

The plaintiff's attorney informed me that the settlement was low, but the patient was "reluctant" because she had made a complete recovery and the medical bills were small.

With regard to arbitration generally, he emphasized the problem of choosing an unbiased and skilled neutral arbitrator. He expecially liked the availability of textbook evidence in arbitration. But he raised the limited scope of appeal from the arbitrator's decision as a serious defect in the procedure, although he added that if he were to win in arbitration he would welcome the limitation. This attorney did very little malpractice work.

Case No. 13: Settlement for $5,000 in September 1970.

On September 27, 1968 the patient came to Ross-Loos Clinic suffering from posterior dislocation and compound fracture of the right talus incident to a motorcycle accident. He was 26 tears old. X-ray identified "extensive avulsion of the right talus posteriorly and medially. Displacement is beyond the confines of the soft tissue which would indicate that this probably is a compound fracture." Thus, this was a very substantial bony injury as well as one which must have been severely traumatic to soft tissue.

There was an operative reduction. The surgeon described a 5 inch laceration on the posterior and medial aspects of the right ankle. There was avulsion of the flexor communis tendon (of the toes) from its muscular attachment.

The patient was discharged after eight days of hospitalization. For the first few days he had a mild fever which was treated with antibiotics. Ten days after hospital discharge his wife phoned the clinic to state the patient was suffering "some terrible pain in his foot". She was advised to bring him to the office the following day. At that time the cast was removed and a small area of skin breakdown about the size of a dime could be seen over the Achilles tendon. There was no evidence of infection. A bandage was applied and a long-leg cast was again placed on the leg. The doctor noted that the patient "appeared to be comfortable" and he was told to return in five weeks for a check-up and another X-ray.

The patient returned in a week, complaining of pain in the ankle. The doctor noted that the circulation in the toes and their motion were the same as when last seen, so the patient was again sent home. Two days later he called to complain of pain, but the office was closed at that time. He then saw an outside orthopedist.

This orthopedist removed the cast and his report states he "found a large area of breakdown of the skin" in the area of the Achilles tendon. This was deep enough to expose the tendon. The new result was a good deal of treatment over an extended period but with eventual, substantial recovery.

> COMMENT: The defense was ready to assert that the patient had not followed instructions for proper care of the cast, maintenance of the foot in an elevated position, and generally taking care of himself. It was the plaintiff's position that there had been inadequate follow-up after an unusually severe injury. Liability in this case seems equivocal. While the Ross-Loos physician who saw the patient on his first visit after hospitalization told him to return in five weeks, the fact remains the patient returned in one week. One may criticize the failure to identify the ulceration at that time, but query if the lesion was significantly worse two days later.

In an interview, the plaintiff's attorney agreed that the medical issues were difficult and he was not certain of winning. He favors arbitration as fast and economical, but he sees these as advantages only in small cases. In a case where a big damages award could be anticipated, he says there is no alternative to the jury system. An in the case of marginal liability with big damages, he felt the size of the injury would encourage a jury to find liability. In such a case, he thought the objective arbitrator would be much more likely to find for the defense.

He was concerned about the dollar cost to the plaintiff in a small arbitration case, since the plaintiff and defense customarily share the cost. He said a single arbitrator would be far more economical.

Case No. 14: Settlement for $500 in January 1968.

In May 1960 the claimant, a middle-aged woman, suffered a Colles fracture incident to a fall. The fracture was casted while there was still a good deal of dorsal angulation in the distal fracture fragment. When the cast was removed the normal wrist angle had been lost and, according to her orthopedist, this caused the patient "to lose grasping power of her hand." Surgery was recommended to normalize the wrist angle.

> COMMENT: This is an unusual result for this type of fracture. The records do not reveal if the physician recognized the malposition when he was about to apply the cast and, if he did recognize it, whether appropriate steps were taken to accomplish adequate reduction. If these steps were not taken then this is a case of liability.

The plaintiff's attorney stated the case had remained dormant for almost five years and the physician who had agreed to testify for the plaintiff had died. He felt the case was so old it would be difficult to develop all of the facts in arbitration. Also, there was great difficulty in reaching an agreement over a neutral arbitrator and he was reluctant to apply to the Superior Court for assignment of an arbitrator because he was not sure that he would like the one he got.

This attorney favors the concept of arbitration, and he said the slowness of this particular case was exceptional. He felt that if an objective, single arbitrator could be assured then arbitration would be a great advantage for all concerned. As had other attorneys, he held an especially favorable view toward the arbitration of small cases. he felt that recovery would be higher in small cases compared to jury awards.

Case No. 15: Settlement for $1,500 on February 19, 1971.

On October 5, 1970 the claimant, a 66-year old man, was seen at the clinic for chest pain of increasing severity over the past few days. His blood pressure and pulse were normal. The general practitioner who saw him referred the patient to an internist in the clinic who saw him within an hour. He wrote, "Very emotional. . . .gets sense of pressure in anterior chest and pain in left arm. Walks a lot without distress. Minor, non-specific EKG changes." He prescribed sedation and nitroglycerine to be used as necessary.

That afternoon, after the patient had gone home, he was seized with a very severe chest pain, was rushed back to the clinic, but was dead upon arrival.

> COMMENT: Because the internist did all the reasonable tests, this is probably a defensible case. In reviewing the EKG I noted minor changes which, in combination with the patient's history, might have dictated hospitalization for a period of observation. The settlement reflects the clinic's willingness to "buy up" quickly cases of serious injury which are headed for litigation. This is sound claims management and a malpractice carrier might well have done the same.

The plaintiff's attorney told me that he does not ordinarily handle malpractice matters. He had no opinion concerning the value of arbitration and felt that the venue for this case had nothing to do with settlement.

Case No. 16: Settlement for $1,800 on May 20, 1968.

The 61-year old female claimant visited the Ross-Loos clinic on June 10, 1967 for treatment of a puncture wound of the right heel. X-ray facilities were not available and there was no mention in the records that the patient had, as she alleged, told the doctor she stepped on a needle. He administered a booster tetanus injection and sent her home.

On June 22 she telephoned to state she had continuing pain. She returned for an X-ray and this revealed a one-inch long needle in the heel. An infection had developed in the meantime and this was treated with antibiotics, etc., before the needle was removed some time later.

> COMMENT: This is a case of liability if the patient told the doctor she had stepped on a needle. The complication of infection enhanced the damages element.

The plaintiff's attorney told me that he thought he received full value for the case, since the patient had completely recovered. He said he would not have taken the case to court, even though he felt there was clear liability, because the damages element was just too small. He preferred arbitration for a case of this size because of the simplicity of the procedure and the saving in time. He emphasized that the main problem in arbitration is to find a sound judge of the facts and he felt this was more likely to be obtained in arbitration than before a jury. At more than one point in our conversation he repeated his lack of confidence in judges and juries to resolve technical fact situations.

Case No. 17: Settlement for $1,350 on October 18, 1971.

This was an unusual case involving tranquilizing medication for a patient who then left the clinic and drove his car into the plaintiff. The injured party then sued the physician for giving this medication to the driver who injured him.

> COMMENT: The injuries were mild. This case could have gone to the Superior Court since the injured party was not a party at Ross-Loos. The case is mainly of interest because of the opinion of the plaintiff's attorney concerning the arbitration.

The attorney stated that arbitration would be a great improvement over courtroom litigation if one had an adequate neutral arbitrator. However, he pointed out that in a case of good liability and severe damages a jury was likely to give more money than an arbitrator. So, "Juries are better for money damages but arbitration is better for deciding liability because the arbitrator is probably going to be more objective and won't be so likely to be biased in favor of the physician."

Case No. 18: Settlement for $500 in August 1968.

The 25-year old librarian who was the claimant in this case was treated at Ross-Loos for iron deficiency anemia. Her physician ordered iron injections instead of treating with oral medication. (Although occasionally iron by injection is indicated, this is uncommon.)

The drug was given on January 5, 1968 for the first time. Within about a day she developed a mild rash and when she came in for her second injection on January 15, 1968 she told the nurse about it. The nurse relayed the information to the physician, but he felt there was no connection to the medication and told the nurse to administer the iron injection. He did not examine the patient. Immediately following the injection the patient experienced severe abdominal pain and manifested multiple bruising. She was hospitalized and a diagnosis of "allergic purpura" was made.

The patient was acutely ill for about a week with severe abdominal pain, distention and new areas of bruising developed for five or six days. She then recovered completely.

> COMMENT: This was a dangerous case. The patient might have developed spontaneous bleeding into her brain, for example. But the 100% recovery made the value of her case low. However, it was greater than $500 and her general practice attorney probably would have won the case, at trial or arbitration, since the liability was clear.

The plaintiff's attorney, who is not a personal injury specialist, stated that he would have pursued the case even if arbitration had not been involved. However, he felt that arbitration made such cases far easier for the non-specialist trial attorney and he liked arbitration for that reason. In cases of big damages, however, he said a jury trial was preferable.

Case No. 19: Settlement for $2,500 in December 1968.

In December 1966 the 33-year old patient in this case was evaluated at Ross-Loos for a Stein-Leventhal syndrome.[14] On July 15, 1966 the patient underwent culdoscopy (which involved insertion of a visualizing scope through the pelvic floor, just behind the cervix, in order to obtain a direct look at the ovaries). The procedure was done on an outpatient basis. The patient fainted and during a period of four hours of observation she became progressively more shocky. She was hospitalized and exploratory surgery revealed about 1,000 cc's of blood and clots in the pelvis due to a "laceration of an ascending branch of the uterine artery on the left." The bleeding was stopped and the ovaries were directly examined. They demonstrated the typical changes of the Stein-Leventhal syndrome, and wedge resections, the appropriate treatment, were performed.

The patient recovered without event. The resections of her ovaries had the desired effect of producing fertility and she later became pregnant.

> COMMENT: This is an unusual case inasmuch as the ultimately indicated ovarian surgery was

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[14] This is characterized by ovarian dysfunction and resulting infertility.

> done in the course of the emergency laparotomy. Was the laceration of the uterine artery a negligent injury? This would seem to be one of the risks of this particular procedure, and the defense might well have won on this issue. Clearly, considering the complete recovery, this is too small a case for the malpractice specialist, yet it involved the sort of fact situation which a general practice attorney probably would not be able to develop adequately.
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> More importantly, at the time of this settlement California's informed consent rule still required an expert witness to establish the standard of the community for eliciting the patient's consent. No case up to that time had been won *solely* on that basis. Thus, failure to warn the patient of the possibility of a hemorrhage incident to culdoscopy probably would not have been an issue at trial. Today, such a case very likely would be won on the consent issue, since many courts are following the rule of Berkey vs. Anderson[15] and are permitting the jury to decide this particular issue without the benefit of expert testimony.

This case happens to have been handled by a firm of malpractice specialists. It is my impression the case was accepted as a favor to the referring attorney. Both the attorney who handled the case and the senior partner told me that they received full value. They confirmed that such a case would not be worthwhile following through courtroom litigation because of the patient's complete recovery.

Despite this fact the senior partner is strongly opposed to arbitration on a philosophical basis. He feels that it constitutes a constitutional denial of the patient's right to a fair proceeding with complete rights to appeal, etc.

Case No. 20: Settlement for $2,500 on July 14, 1969.

This was a complicated case, concerning a two-year old boy with a fulminating pneumonia. The patient was seen at a suburban Ross-Loos clinic on August 8, 1967, conplaining of extreme irritability and fever. There were no other positive physical findings. He was given an antibiotic but the fever continued. He then developed respiratory difficulty and was admitted to the hospital on August 13. A diagnosis of bilateral pneumonia with empyema was made, and more intensive antibiotic therapy was initiated. After, transient improvement respiratory distress became much worse and he developed heart failure. He then deteriorated rapidly and died on August 20, 1967.

The major liability issue concerns the supervision of the child between the 8th and 13th. The mother had a telephone contact with the clinic on the 12th and was told it was unnecessary for the child to be examined that day. Hospitalization was accomplsihed the next day. Query just how much influence the 24-hour delay may have had.

> COMMENT: This was a case of fulminating pneumonia with runaway characteristics. The defense would have asserted that since the mother did not telephone the clinic until the 12th, there was not the opportunity to intervene at a sufficiently early time to have any chance at accomplishing a cure. This is a case which is probably defensible both in arbitration and before a jury.

The patient's father was a lawyer and he referred the case to a malpractice specialist, the same one who handled case No. 19. He has told me that he felt the case presented difficulties in establishing liability and he said there were few cases where the death of a small child has resulted in large damages. Again I have the impression that he accepted the case as a favor to the father.

This attorney's opposition to arbitration, on philosophical grounds, was noted above.

Case No. 21: Settlement for $14,000 on September 29, 1969.

On March 23, 1967 the claimant, a 64-year old man, was subjected to a sigmoidoscopy. This was done on an out-patient basis. Although he had moderate complaints during the procedure, his physician noted that they were no more strident than during a sigmoidoscopy four years earlier.

Several hours after the patient returned home he complained of stabbing abdominal pain. He was immediately hospitalized and a small perforation, obviously caused by the instrumentation, was identified. At surgery the perforation was repaired and a transverse colostomy was done.

The patient did well and the colostomy was closed in April 1967. During the convalescence, an obstruction of the left internal carotid artery was identified. This was associated with some personality change but no other neurologic deficit. If the case had been arbitrated, the plaintiff's attorney would have specualted about the possible relationship between his illness and the thrombosis.

> COMMENT: This was a case of clear liability. However, the patient did remarkably well. Consultants did not feel that the carotid obstruction occurred soon enough after his injury to establish a cause and effect relationship, and the patient's attorney told me that he felt this was a rather tenuous damages issue.

The plaintiff's attorney was not a malpractice specialist. In an interview, he told me that he felt the settlement was a fair one. He said he would have accepted the same settlement if the case had been proceeding to a court trial.

This attorney favors arbitration, feeling that it is likely to be quicker and more efficient than a jury trial. He added that the same goal could be achieved by court trials, that is trials without a jury, and he felt that it might be easier in an administrative sense to find medically sophisticated and unbiased judges than it would be to obtain neutral arbitrators acceptable to both the plaintiff and defendant.

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[15] 1 Cal. 3d 790 (1969).

Finally, as was true in other interviews, this attorney felt arbitration is, at least in theory, ideal for the non-specialist in the malpractice area. The availability of textbook evidence and the greater objectivity of an arbitrator, as compared to a jury, were mentioned in this regard. This attorney, more than most others, felt little confidence in the ability of lay juries to deal with scientific facts.

DISCUSSION OF CASES INVOLVING LEGAL COUNSEL

In each of the above cases the Ross-Loos Medical Group was represented by the same law firm --- usually by the same attorney. As might be expected, these attorneys regard malpractice arbitration as efficient and fair. Considering the ease of pursuing arbitration, they regard it as remarkable that so many attorneys "fold" when they learn that a case must be arbitrated instead of tried before a jury. They offered no explanation for the phenomenon, but I have speculated above on one possible cause.

Interviews with the plaintiffs' attorneys in the above cases elicited a considerable unanimity of opinion. Most agreed that, providing a skilled and unbiased neutral arbitrator was obtained, a more objective appraisal of liability issues would be had through arbitration than through jury trial. Why, then, was there support for arbitration in small cases but not in big ones? The answer is obvious: The economy of arbitration, especially in terms of time spent in court, makes pursuit of the small case economically justifiable. And it was assumed that the outcome in arbitration would be more predictable, so the valid (assuming it was accurately evaluated by the attorney) case should have a better chance in arbitration. But the severe injury case usually has good jury appeal and should result in a higher award than the same case before the presumably more objective arbitrator.

Assumptions concerning the objectivity of the neutral arbitrator were illustrated by some additional comments. In cases of marginal liability and severe injuries, several attorneys felt the jury would be influenced by the injuries and thus find liability. Case No. 2, involving a brain abscess, illustrates this fact situation. A jury almost certainly would have ignored complex questions of causation and found for the plaintiff, whereas the arbitrator apparently ruled for the defense on the causation issue. On the other hand, a case may present a complex liability question where negligence would be obvious to the skilled observer but obscure to a lay jury. Some attorneys noted that in this situation arbitration would be preferable even though damages were severe.

CASES IN WHICH ATTORNEYS WERE NOT INVOLVED

Cases 22 through 35, considered next, involved indemnities paid to patients who chose to settle their cases without obtaining an attorney. All but two of these cases occurred since 1970 and reflect a change in medical administration, with a new policy toward early disposal of cases.

These cases are of particular interest because a number of them involved minor injuries, so minor that it is unlikely an attorney would have pursued them through conventional litigation (that is, if a patient had not been bound by arbitration) even if he had decided negligence was present. One can speculate, therefore, that the comparative simplicity of the arbitration mechanism encouraged the defense interests to settle these cases before an attorney came into the picture. This motivation would exist whether or not the case seemed defensible (and, in fact, the great majority fell into that category), because a small settlement obtained early in a case is more economical than the expense involved in winning it.

But there is another motivation too. Sound clinic administration may dictate modest compensation to the patient who has some basis for feeling aggrieved, even if there is little prospect that he will ultimately seek vindication by demanding arbitration. As explained in my Introduction, the clinic administration has a free hand in such cases, because of their loss retention.

Now place the arbitration agreement in the context of a private physician or a group which did not have a loss retention. Would the malpractice claims manager feel motivated to settle these minor cases even if he felt quite certain he could win in an arbitration? As I have discussed above, if such a case is headed for court the claims manager must resist settlement. In this way he discourages the filing of small cases which may not justify the attorney's expenses and time even if he should obtain a jury award. If malpractice arbitration becomes popular with attorneys generally, and they find it economical and efficient in terms of time expended, this barrier to the small and/or equivocal-liability case will disappear.[16] So the ultimate effect of arbitration on small cases must remain speculative.

Suffice to say that it is not the *actual* arbitration of small cases at Ross-Loos which provides evidence on this point; none of the three arbitrations analyzed was small. Rather, it is the Gestalt created by arbitration which seems to be the influential factor in these settlements.

Case No. 22: Settlement for $933 in August 1971.

The 25-year old man who was the claimant in this case suffered a low back injury in July 1970. His subsequent complaints to his physician at Ross-Loos were persistent and strident. Several months of conservative treatment did not improve him to the point where he could return to work, and he then consulted an outside orthopedist. This physician performed a lumbar laminectomy, identifying a large herniated intervertebral disc. The spinal fluid protein at time of surgery was 60 mgs%.

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[16] This is not to say that the malpractice carrier never settles a trivial injury case. Where liability is completely clear, and the fact situation is relatively simple, settlements are not infrequently made. But where there is equivocation about liability, settlement is almost never achieved in the minor case. It is then that the expense of conventional litigation operates to deny the patient any recovery. It is noteworthy that a number of the cases described below fall into this category of marginal liability.

> COMMENT: Conservative management is a well accepted approach to low back complaints where the neurological examination is normal, as was true here. However, if the orthopedist had performed a spinal tap and identified an elevated spinal fluid protein this probably would have led to myelography and earlier surgery. However, surgery was very successfuly so the patient's only damages consisted of a certain amount of time lost from work and a longer period of discomfort than was necessary. His prospects for litigation were very poor. It is doubtful that either a jury or an arbitrator would decide that his physician's conduct was substandard.

Case No. 23: Settlement for $1,750 on May 11, 1971.

In September 1970 the 56-year old female claimant in this case was subjected to a vaginal hysterectomy with repair of a cystocele and rectocele. Surgery was clearly justified and the operative report suggests the technique was routine.

Immediately after the operation, the patient manifested a vesico-vaginal fistula. This was repaired on February 24, 1971. On April 6, 1971 a chart entry described complete healing of the lesion. At no time was the fistula especially severe; there was only a small amount of dribbling from the vagina. Thus, the major disability from the complication was the necessity for the second surgery.

> COMMENT: Vesico-vaginal fistula following even an uncomplicated hysterectomy is by no means a sure win for the most skillful malpractice attorney. Where remedial surgery is completely successful, a jury is that much less likely to bring in a plaintiff's verdict. If it does, the award will not be high. In the case at hand, the surgery was more complicated than usual. So a plaintiff's jury verdict does not seem likely although I query what the result from an arbitration would have been. Certainly in the absence of arbitration this is the type of case which would not be settled by a malpractice carrier.

Case No. 24: Settlement for $3,000 on August 22, 1969.

The patient, a 40-year old housewife, came to Ross-Loos clinic on February 3, 1969 complaining of right flank pain. A presumptive diagnosis of urinary tract infection was made. She was improved on April 7 but on April 24 she telephoned the clinic to say she had been "acutely ill for two or three days with abdominal pain, bloating and vomiting." She was seen by a house call physician but no definitive diagnosis was made.

On April 23 she was pain free but on May 15 her vomiting returned. Over the following week there were X-ray evaluations of her kidneys, gall bladder, chest, and upper gastro-intestinal tract. It was felt her symptoms were mainly based on nervous tension.

On July 25, 1969 a questionable mass in the right lower quadrant was identified. She was hospitalized and an exploratory laparotomy identified a 145 gram mass at the proximal end of the Fallopian tube and an enlarged, cystic ovary.

> COMMENT: Should this mass have been identified earlier? Did it have anything to do with the patient's nausea and vomiting, even though it probably was related to her pain complaints? On November 26, 1968 a pelvic examination was normal, yet there was no further pelvic exam despite her complaints. It is my estimate that there was no malpractice here and the case was defensible. It is the type of case which the skillful malpractice attorney would not accept, both because of the equivocal liability and very small damages potential. A malpractice carrier would not settle such a case if it were headed for a jury trial.

It should be kept in mind that either a hospital or a medical group with an all-expense retention (and where the administration assumed the responsibility for claims handling) would have a motive to settle this type of case whether it was headed for courtroom litigation or arbitration. The motive, of course, would be to save the expense of litigation. The administration at Ross-Loos estimates that a case carried through arbitration costs about $3,000 on the average.

Case No. 25: Settlement for $3,000 on October 8, 1971.

The claimant, a 48-year old man, suffered a "cautery-type of cut from a hot ignition wire" on his right index finger on May 29, 1970. He was immediately seen by a Ross-Loos physician who identified a severed digital nerve and this was re-approximated. The sheath of the flexor tendon was cut but the doctor thought the tendon underneath was not damaged.

However, upon recovery the patient discovered he could not flex his finger well and on July 10, 1970 a second operation was done. It was discovered that the flexor profundus tendon was divided and re-approximation resulted in only partially satisfactory return of function.

The patient claimed there was a negligent failure to identify the cut tendon on the occasion of the first surgery, and he asserted it would have been simpler to treat the problem successfully at that time.

COMMENT: This is a case of equivocal negligence. Even if one assumes there was a negligent failure of diagnosis on the first visit, it is questionable whether the result would have been different with immediate treatment. As with the previous case, this is one which is probably too small to be accepted by a plaintiff's malpractice attorney. It involved complex medical questions, with regard to both negligence and causation; so a general practice attorney who took this case through conventional litigation very likely would lose.

Case No. 26: Settlement for $1,500.

On March 20, 1971 this patient was hospitalized for nausea incident to partial pyloric obstruction secondary to a duodenal ulcer. The patient was treated conservatively for a time and then surgery was accomplished on April 6. In the course of surgery the spleen was "found to be bleeding" and had to be removed.

COMMENT: The data in the medical records are insufficient to estimate the liability issue raised by this splenic bleeding. The patient was mainly concentrating on the presumed negligence associated with the delay in accomplishing surgery, but it is very doubtful if this raises a legitimate issue. Persistent drainage and conservative treatment may be successful in relieving a partial obstruction secondary to an acute ulcer and this is perfectly rational treatment. Would the issue of splenic injury have arisen later? This possibility made the case well worth settling. Again, this is the sort of a case which the malpractice specialist probably would not accept. Removal of the spleen carries with it no provable permanent disability, and so even if an attorney felt liability could be shown, the damages potential for this case was small.

Case No. 27: Settlement for $1,448 in June 1971.

The 39-year old male claimant in this case presented a long history of eye problems. Bilateral cataract surgery early in 1971 was accomplished and the patient was apparently dissatisfied with the results. This is the only case reviewed in which adequate records were not available.

COMMENT: The size of the settlement suggests a case which would not have been acceptable to a malpractice specialist. More cannot be said in view of the lack of information.

Case No. 28: Settlement for $1,327 on January 27, 1972.

On February 26, 1971 the claimant, a 62-year old woman, was subjected to a bilateral bunionectomy which was followed by stubborn infection in the left foot. The infection was recognized in a timely manner and treated appropriately. Ultimately there was a complete cure.

COMMENT: Postoperative wound infections, in and of themselves, do not often raise a solid malpractice issue. When these cases are won by the plaintiff there is almost always an associated delay in recognition of the infection and/or a failure in carrying out appropriate treatment. Clearly this was too minor a case to be accepted by a malpractice specialist, and too complex a case to be won before a jury by the non-specialist attorney. It very likely would not have been won in arbitration.

Case No. 29: Settlement for $4,480 on December 13, 1971.

This patient was subjected to a subtotal colectomy and iliostomy for ulcerative colitis in 1969. There was another hospitalization on June 2, 1970 for removal of the rectal stump. In the course of this surgery the prostatic urethra was severed. This was recognized quickly and re-operation was successful

COMMENT: In this type of case the defense argues that there is a calculated risk of the particular injury and the plaintiff's attorney denies it. As with some of the previous cases, the successful and immediate re-operation not only reduces the value of the case but would tend to promote a defense verdict from a jury. It was the administration's opinion that the patient was ready to obtain an attorney and pursue this case through arbitration. The results there are speculative. This is another case where the damages potential are not great and a malpractice specialist probably could not afford to take such a case to court.

Case No. 30: Settlement for $10,000 in October 1969.

On August 5, 1966 the 20-year old housewife who was the claimant in this case, had a colpotomy to rule out the possibility of a tubal pregnancy. A local infection developed at the colpotomy suture line and it was felt that antibiotic treatment was effective. On September 13 she was admitted to the hospital with a diagnosis of "incomplete abortion, early, probably secondary to pelvic infection."

A dilatation and curettage was performed and 12 hours post-operatively she developed signs of peritonitis. She was taken to surgery at 7:00 p.m. on September 14 where the colpotomy incision was opened and 150 cc's of pus and blood were draimed from a pelvic abscess. Over the subsequent 24 hours the patient did not progress well. She had a severe ileus and seemed to be deteriorating. She was therefore taken to surgery where a total abdominal hysterectomy was done. Abscesses were drained in each iliac fossa and from beneath the diaphragm. The pathologist identified a perforation in the uterine fundus which presumably occured at the time of the D&C.

> COMMENT: This is an interesting case which presents a series of untoward events, any one of which might well be explained by the defense and yet, in their combination, would virtually guarantee an adverse verdict from a jury. The initial infection is within the risk of the procedure. It was recognized and treated in a timely manner, and the fact that the infection was not handled by the antibiotic therapy does not establish the proposition that there was substandard management. Similarly, curettage of the pregnant uterus carries a risk of uterine perforation despite competent technique. Perhaps re-operation should have been accomplished sooner, but this is speculative, judging from the medical records. If the case had been arbitrated there was a definite risk of liability for the physician, but this author thinks it is much less than if it were tried before a jury. It is a type of case which the malpractice specialist probably would accept, and he probably would not have settled for $10,000. However, this was a net recovery for the patient and, assuming a 50% contingent fee, represented a settlement by an attorney for twice this amount.

Case No. 31: Settlement for $1,000 on August 26, 1971.

In January 1970 the patient in this case was examined by an internist at the Ross-Loos clinic for chest pains which were not typical of angina. An EKG was interpreted as demonstrating a subendocardial infarction of uncertain age. The patient was told to remain in bed for three or four weeks, but he was not hospitalized.

He then saw an outside cardiologist who said the EKG pattern was due to ventricular hypertrophy. This author's comparison of the tracing with one taken several years earlier confirms the diagnosis of ventricular hypertrophy. The internist at Ross-Loos, however, had not obtained this earlier tracing in order to make the comparison.

The patient was a lawyer and was prepared to pursue the case through arbitration. He alleged that the diagnosis of subendocardial infarction of uncertain age had made him anxious, etc.

> COMMENT: The damages in this case were extremely nebulous. Settlement seems mainly to have been made in order to save the expense of pursuing the case.

Case No. 32: Settlement for $1,325 in October 1971.

This 61-year old patient suffered a fracture of the right ring finger in an accident on April 6, 1967. He did not report to the clinic; instead he requested a house call. Apparently there was a problem in adequate communication over the telephone, and no house call physician was sent. The ultimate result was a delay in identification of the fracture with a residual disability suggesting sympathetic dystrophy. This was only temporary; ultimately the patient recovered completely.

> COMMENT: This was an unusual, although comparatively minor, problem which was not unequivocally related to the delay in treatment. It is very doubtful that negligence was involved, although juries tend to be sympathetic with the patient who alleges a disability because a physician would not make a house call. The defense response is obvious—Why did the patient not come out to the clinic? The arbitration result would very likely have been favorable to the defense.

Case No. 33: Settlement for $989 in September 1971.

On January 5, 1970 the child who was the patient in this case experienced injury to her right foot when a garage door fell on it. She was taken to the Ross-Loos Clinic where X-rays were read as negative. Two weeks later, because of persistent swelling, a repeat X-ray was made. This identified a "slightly displaced fracture of proximal phalanx second toes, right foot." The foot was casted for a month and the patient recovered completely.

> COMMENT: A review of the original films demonstrated the fracture, even though it was obscure. This type of case usually results in a plaintiff's verdict. Yet, with complete recovery the value of the case would be very low. But the case is so simple that a general practice attorney probably could be found who would take it to court and he probably would win. For arbitration the case would require no more than one-half day, and the patient probably would have no difficulty in finding an attorney to represent her. The settlement, therefore, was well advised.

Case No. 34: Settlement on June 17, 1971 for $1,000.

In the Fall of 1968 this patient came to Ross-Loos for treatment of low back pain. He requested surgery, but his physician decided to treat him conservatively. After several months he went outside the clinic and found a physician willing to operate. This was accomplished in the summer of 1969 and allegedly a ruptured lumbar disc was identified.

The patient contended there was a negligent delay in not accomplishing more aggressive treatment.

> COMMENT: Clearly there was no substandard treatment here. Conservative management for low backaches is well accepted. At no time did

> the patient have positive neurological findings. The plaintiff would have little chance for success either in a courtroom or in arbitration. This again illustrates the Clinic's willingness to compromise where the patient will accept a modest settlement.

Case No. 35. Settlement for $9,500 in February 1970.

On March 4, 1968 the claimant, a 52-year old woman, came to the ENT clinic, complaining of a sore throat for six weeks. The physician who examined her noted that she had recently "got over a cold, smokes, and does a lot of talking." On examining her larynx he stated, "Inflamed, cords red with some mucoid bridging. No other abnormalities."

She returned to the clinic on July 10, 1968 and another physician wrote, "Larynx normal. Functional dysphonia. Explained."

On March 28, 1969, the next visit, a third physician wrote, "Functional aphonia, try Fiornal tablets as mild sedative. Reassured." The medical records do not describe an examination of the larynx on this occasion.

On the next visit, July 9, 1969, she was seen by two physicians in succession. The first recommended a direct laryngoscopy, and the second wrote, "Functional dysphonia. Refer to psychiatrist."

The patient then went to UCLA and she was admitted to the hospital on August 5, 1969. Direct laryngoscopy identified a polyp of the right vocal cord. This was removed and proved to be an epidermoid carcinoma. The patient was treated with cobalt therapy.

In addition to the $9,500 settlement, the defense agreed to pay future medical expenses related to this illness.

> COMMENT: This is a case of liability. Although it is not perfectly clear from the records, apparently the patient was felt to have a good prognosis. The amount of the settlement leads to the same conclusion. A jury verdict in this type of case, even with a good prognosis, might be substantially greater than $9,500.

Claims Incidence

A "claim" is an instance of medical injury which someday may result in an insurance loss. Usually such cases will require the setting of a reserve by an insurance claims manager. A file will be opened on the case and it will become a part of the statistical analysis of the year in which it occurred, even though the case may be ultimately closed without payment of indemnity or even significant expense.

In an effort to determine the claims incidence at Ross-Loos, 144 files closed in 1970 and 1971 were reviewed. Files prior to that time were not available. As indicated above, each of these cases was set aside by the executive secretary because it might present a particular problem. Thirty files reflected only disputes over outside care costs, so they were excluded. Of the balance of 114, most of them were so trivial (mostly "gripes") that it would not be reasonable to characterize them as claims. Applying reasonable standards, therefore, 11 cases in 1970 and 14 in 1971 should be characterized as claims. However, to these cases in the active file must be added the closed cases which reflected alleged injuries arising in 1970 and 1971. This yields a total of 17 claims for 1970 and 19 for 1971.

Claims incidence is reported as a percentage figure, reflecting the number of claims per 100 physicians. The above figures translate to 14.17 percent in 1970 and 15.57 percent in 1971.

The Legal Expenses and Loss Analysis

It is impossible to characterize these in terms of cost per closed case, or a similar statistical expression, because claims incidence is not recorded by the Ross-Loos group. Because the group has a large retention there is no intervention by the insurance carrier, so claims handling is not routinized and customary insurance statistics are not recorded. However, it is possible to record both legal expense and loss in terms of physician years.

LOSS (INDEMNITY PAID OUT IN SETTLEMENTS AND VERDICTS) PER PHYSICIAN YEAR:*

Year	Loss	No. M.D.'s	Loss Per M.D. - Year
1964	$ 24,250.00	112	$216.52
1965	82,500.00	113	730.09
1966	70,000.00	112	625.00
1967	42,175.00	113	373.23
1968	14,300.00	115	124.35
1969	29,500.00	118	250.00
1970	18,000.00	120	150.00
1971	$100,275.00	122	821.93
Totals:	$381,000.00	925	Average Loss/M.D. Year $411.89

*Figures for 1972 are incomplete, and therefore not tabulated.

LEGAL EXPENSE PER PHYSICIAN YEAR:

M.D. Years 1967 through 1971 = 588
Legal Expense 1967 through 1971 = $54,237.67
Average Legal Expense per M.D. Year = 92.24
Legal Expense Per M.D. Year:

1967 = $ 24.75
1968 = 61.58
1969 = 80.77
1970 = 133.04
1971 = 154.63

Discussion:

The clinic's legal expenses (and these are available only since 1967) consist almost entirely of attorney's fees. The clinic has no expense for investigation and only very low expenses for their few arbitrations. The expenses were only available to me as a gross figure for the five-year period. Cases during this time which were closed with and without payment, as well as some cases which are still active, account for this expense.

The loss per physician-year is a figure subject to wide fluctuation because of the small number of physicians involved and the occasional large loss. Thus, in 1965, 1966, and 1971 a single indemnity severely altered the loss per physician-year figure. But with no unusual indemnity in the years 1967 through 1970, the loss per physician-year is remarkably low.

Conclusions

There are four reasonably definite conclusions which can be drawn from this study. First, for the physicians at Ross-Loos arbitration is an unqualified success. Considering the paucity of arbitrations, it might be concluded that it is the administration's policy of settling cases which mainly accounts for the physicians' peace of mind and not the existence of this alternative to courtroom litigation. However, just as the private practitioner who has never been sued may feel increasingly uncomfortable about the prospect, so the Ross-Loos physician feels reassured by the fact that if ever the ax should fall he will not in an open court; his case will be handled in the comparative privacy of an attorney's office and with a minimum delay in the proceeding itself.

Second, for the defense the arbitration proceeding is economical. Despite the fact that there are only three cases from which to draw conclusions, in at least two of them I feel certain that a court trial would have been far more lengthy than the arbitration hearing. If one assumes that the expense of various discovery proceedings would be the same when preparing for arbitration or a court trial (which was not the case at Ross-Loos), there still would be a substantial saving because of the limited time required for the arbitration. From the patient's standpoint, however, the arbitrators' fees are an expense which is not duplicated in the civil trial. Nevertheless, considering the various economies enjoyed by the plaintiff's attorney (the absence of a jury fee if he loses, the substitution of textbook evidence for a possibly expensive expert witness, the fact he will not require a transcript either to prepare a closing argument or in case of appeal, and the shorter time required), it does not seem unreasonable for the attorney to shoulder the cost of the arbitration. Without question, a substantial economy would be achieved if the two parties could agree on a neutral arbitrator and forego the other two arbitrators.

Third, both explicitly and by implication, the attorneys who were interviewed for this study seemed to agree on this point: The properly selected neutral arbitrator will be objective. Several judgments (even though the Ross-Loos arbitration experience is too limited to test them) seem to follow from this conclusion. Arbitration should be advantageous for the small case. Whereas a jury tends to be sympathetic with the physician, and so may ignore the evidence for negligence if the patient has suffered only minor injury, the objective neutral arbitrator should be more likely to find liability. And when venue is in a rural county, even the big case is better tried before an arbitrator. Rural juries are notorious for standing behind the home town physician unless negligence has been very clearcut. Several attorneys mentioned that the complex medical case, even in a metropolitan area, was better tried before an arbitrator because, assuming liability, he would be more likely than a jury to discern that fact. Others pointed out that the case of severe injury with equivocal liability was better tried before a jury, since its sympathy for the patient would overcome the plaintiff's difficulties in proving negligence. Virtually all of the attorneys agreed on the superiority of a jury trial where liability could be proven. Why? Because the more objective arbitrator probably would give a smaller award as compared to the jury whose sympathies had been stimulated by skillful advocacy.[17]

Fourth, the existence of arbitration at Ross-Loos has not promoted a plethora of suits. This matches the experience of Casualty Indemnity Exchange[18] and of the eight-hospital project in Southern California. Data are not yet available from Southern California-Kaiser. If the continuing experience at CIE and the developing experience at Southern California-Kaiser reveal a claims incidence approximately equal to that of the other carriers in California, perhaps the most serious theoretical objection to arbitration will have been removed. One must add the caveat that, after a number of years, the possible increasing sophistication of plaintiffs' attorneys plus the ease of arbitration might cause a substantial increase in claims.[19] But there has been a striking increase in claims incidence for the major California carriers despite the impediments associated with conventional litigation. In short, guessing at claims incidence under various conditions is a highly speculative game.

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[17] Although argumentative, one is tempted to ask if the attorneys should have it both ways. The more accurate resolution of facts in small cases or those of unusual complexity where liability seems to apply, and the less objective jury where the attorney is confident that he can win on the negligence issue and wants as high an award as possible.

[18] CIE has a policy of noting every communication from a physician regardless of its significance in terms of liability risk. Thus, many of their incidence reports do not amount to claims. The incidence of their claims is not significantly higher than that of other malpractice carriers in California.

[19] Perhaps the greater simplicity of arbitration would make it just to impose a legislative limit on contingent fees. This author is one of those who doubt that this would decrease the number of claims, but it might have the effect of reducing awards and so a possible increase in the total number of awards might thereby be balanced. If this occurred, coupled with the greater economy of arbitration, the malpractice carriers' loss ratio might not be worsened and perhaps would even be benefitted. Again, these are speculative matters.

An additional conclusion might be made from this study: There is something about arbitration which seems to discourage the plaintiff's attorney in his pursuit of a claim. Of 36 cases filed in the Superior Court since 1966 (under the assumption by the plaintiff's attorney that there either was no arbitration agreement or else it was invalid), 23 were left inactive by the plaintiff's attorney after he was directed by the court to arbitrate.[20] The reason for this phenomenon is somewhat obscure, but, as I have discussed above, it may well have something to do with the attorney's comparatively greater skill at rhetorical device, as compared to his analytical ability when dealing with medical facts. Given a "handle" on a couple of jury-appealing facts in a malpractice case, his skill at advocacy may carry the day. But before an arbitrator, one assumes that the attorney must mainly win on the facts alone.[21]

This study does not tell us how difficult it may be for the private practitioner to sign his patients to arbitration agreements. Conversations with a number of physicians insured by Casualty Indemnity Exchange indicate that this is not a problem. The executives from that company have told me that few physicians who request the arbitration option in their policy have failed to obtain the required 90% cooperation from their patients.

Finally, from the patient's point of view the most serious defect in conventional litigation is the failure of that system to compensate minor injuries which have left no residual disability. The patient who suffers an extra $500 in hospital bills and a month longer away from his employment than he anticipated may regard this as a serious financial hardship. Sometimes these cases are associated with such obvious negligent injury (leaving a foreign body behind in the surgical patient, for example) that the malpractice carrier will settle immediately. But given any equivocation over negligent treatment, the carrier will usually choose to fight. This means that the patient must go uncompensated, because the malpractice specialist cannot afford the time to accept his case and non-specialist attorney will either also refuse the case or, if he accepts it, is likely to lose if the facts are at all complex. Does an arbitration system treat this patient more fairly? The willingness of the Ross-Loos administration to settle cases makes it impossible to give a categorical answer to this question. Some of their settlements for minor injuries undoubtedly anticipated the patient's successful experience in arbitration. But others were either an acknowledgment of the economy in settling a case for less than the cost of arbitration or else a gesture of fairness toward a patient who sincerely felt he had a justified claim.

The ongoing experience with binding arbitration in California will undoubtedly answer the question of fairness to patients with small claims and will supply information on other issues raised in this paper. The experience of Southern California-Kaiser, expecially, with its almost 1,000,000 subscribers, will be followed with interest.

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[20] Obviously, none of these 23 cases was available for analysis. However, in every case it is apparent that the plaintiff's attorney found sufficient merit in the patient's position so that he decided to file an action. Perhaps, after deposing medical records and obtaining an evaluation from a friendly physician, several of these cases would then have been dropped. But in none of these did the plaintiff's attorney even proceed that far. So it seems reasonable to assume that most of these cases were not dropped because the plaintiff's attorney changed his mind about their possible validity; the fact of arbitration must have had something to do with his inactivity.

[21] A couple of the attorneys who were interviewed spoke of the advantage arbitration gives the general attorney who may not be able to develop the facts in a logical and persuasive manner. This author gathered that they felt the lack of finesse would not be penalized by the well-informed arbitrator. Especially with the availability of textbook evidence, this seems a reasonable supposition.

Appendix I

ROSS-LOOS ARBITRATION AGREEMENT

ARBITRATION: In the event of any controversy between a Member (whether a minor or an adult), or the heirs-at-law or personal representatives of a Member, as the case may be, and Ross-Loos (including its agents, employed physicians or employees), whether involving a claim in tort, contract, or otherwise, the same shall be submitted to binding arbitration. Within fifteen (15) days after any of the above named parties shall give written notice to the other of demand for arbitration of said controversy, the parties to the controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. All notices or other papers required to be served shall be served by United States mail. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the California Code of Civil Procedure.

Appendix II

STATISTICAL INTERPRETATION

by
William R. Pabst, Jr., Ph.D.

The basic text of the report describes in detail 35 medical malpractice cases arbitrated or settled by the Ross-Loos Medical Group in the period from 1964 through the early part of 1972. The purpose of this appendix is to bring the information from these 35 cases together and construct a quantitative picture of the malpractice situation in this activity during these years. This quantitative summary of the cases will make it possible to compare the Ross-Loos malpractice experience with that observed in other places, especially in Pima County, Arizona, during these years.[1]

The 35 cases include all those known to be closed during this period, although as the report says on page 000, "there is no central file identifying closed malpractice claims prior to 1964." In addition to these 35 closed files, 144 active files covering 1970 and 1971 were examined to obtain the information on claims incidence as reported on page 00. For obvious reasons, no case by case information is made available on these open cases. Nor is there any information available about the total number of malpractice claim files that may have been opened in the years prior to 1970. Therefore, this appendix deals primarily with thc 35 closed cases as described in detail in the text from page 425 through 442.

Table 1 lists the 35 closed cases, and gives the amounts of judgments or settlements: the dates indicated; the sex and age of patient, when available; the diagnosis, treatment, negligence, and injury; the severity of injury; and an indication by Dr. Rubsamen whether the case was considered a probable liability case or not. All these data are developed from the narrative summaries of the cases. In the case of any question of the tabulated entries, the narrative summaries of the cases should be consulted. The time-span involved in each case is computed in months from the initial event until the arbitration end or settlement date. The severity of injury code is a judgment based upon the scale given in the report by Bird Associates on alternatives to litigation.[2]

The 35 closed cases fall into three groups. The first group includes the cases numbered 1, 2, and 3, which went to formal arbitration. The second group, numbered 4 through 21, those settled with attorneys. fall rather evenly in numbers into the years from 1964 onward. The third group, cases numbered 22 through 35, entitled "cases not involving an attorney," are heavily concentrated in the year 1971. These three groups of cases are so different in many of their characteristics that they are analyzed separately and compared, rather than combined.

The Three Cases Arbitrated

Few generalizations are possible about these three cases that went to formal arbitration, except that they involved medical incidents dating from the 1960's specifically 1960, 1962, and 1967. One of the surprising things uncovered by the study of the Ross-Loos arbitration experience is that there are only three cases that went to formal proceedings during all these years. In the three cases, the arbitrators found for the defense in two and made the substantial award of $70,000 in the other. Two of the injuries involved death. The time span of the cases, from the medical incident to the arbitration decision, were two, three, and five years. The reviewer scored two of the three cases as "probably liability cases" before a jury, and indicated that the amount awarded in the one case was considered "fair". He also felt that, had action at law been available rather than arbitration, the finding for the defense in the second and third cases is doubtful. Nothing really distinguishes these three cases from the many malpractice actions at law to allow even the suggestion, and, certainly not a conclusion or hypothesis, that arbitration, as experienced in them, is different from litigation in observed characteristics.

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[1] See "Alternative to Litigation, I: Technical Analysis," *Supra*, pp. 214ff.

[2] Ibid.

TABLE 1
SUMMARY TABULATION OF ROSS LOOS MALPRACTICE CASES

Case No.	Amount	Duration			Case Factors						Opinions and Comments
		Date of Incident	Date Resolved	Elapsed Years	Claimant Sex/Age	Diagnosis	Treatment	Claimed Negligence	Injury	Severity	
ARBITRATED											
1	$70,000	1962	8/65	3	M/52	Nosebleed	Transfusion	Insufficient therapy	Death	9	Fair;nondefens
2	0	3/67	2/71	4	M/59	Headache	Arteriogram	Failure to detect abscess	Death	9	Doubtful;nondef
3	0	7/60	9/62	2	F/3	Vomiting	Thorazine	Drug side effect	Slurred speech	5	Doubtful;nondef
SETTLED PRIOR TO ARBITRATION											
With Attorney											
4	80,000	6/67	3/71	4	F/41	Lumbar Surgery	Surgery	Perforation of artery	Death	9	Fair;nondefens
5	9,000	9/66	4/68	2	M/52	Diff. to Swallow	Tests	Failure to diagnose cancer	Delay in recovery	2	Fair;equivocal
6	32,175	10/55	2/67	12	M/adult	Ulcerative colitis	Colostomy	Foreign body left	Infection; delay in recovery	4	Fair; nondefensible
7	65,000	1955	11/66	11	M/50+	Back injury	Surgery	Anesthesia	Paralysis	5	Fair;nondefens
8	17,500	1/60	11/64	4	F/53	Bursitis	Cortisone injection	Bone puncture at injection	Partial paralysis	6	Fair, but low; nondefensible
9	10,000	12/57	6/67	10	F/13	Femur fracture	Nail	Postoperative infection	Scar and limp	5	Fair, but low; nondefensible
10	12,500	12/60	7/65	5	M/46	Angina pectoris	Tests	Failure to diagnose myocardial infarction	Death	9	Fair; defensible
11	3,500	12/68	1/70	1	M/42	Foot callus	Surgery	Incorrect approach	Painful foot	4	Fair;nondefens
12	6,750	1/62	9/64	2	F/adult	Acute anxiety	Xray & tests	Failure to diagnose implanted foreign body	Delay in recovery; pain	3	Low;nondefens
13	5,000	9/68	9/70	2	M/26	Rt talus fracture	Open reduction	Insufficient therapy	Delay in recovery	4	Fair;equivocal
14	500	5/60	1/68	8	F/50+	Wrist fracture	Cast	Bad alignment of wrist	Partial loss use of hand	5	Low;defensible
15	1,500	10/70	2/71	< 1	M/66	Chest pain	Sedation	Failure to diagnose heart disorder	Death	9	Fair;defens
16	1,800	6/67	5/68	1	F/61	Heel puncture	Tetanus	Failure to diagnose implanted foreign body	Delay in recovery	4	Fair;nondefens
17	1,350	1970	10/71	< 1	M/adult	Auto accident & medication	Tranquilizing medication	Failure to provide proper supervision	Unknown	2	Unusual; 3rd party injury
18	500	1/68	8/68	< 1	F/25	Iron def. anemia	Iron injections	Injection reaction	Delay in recovery	4	Low;nondefens
19	2,500	12/66	12/68	2	F/33	Stein-Leventhal syndrome	Culdoscopy	Laceration of artery	Delay in recovery	2	Fair;defensible
20	2,500	8/67	7/69	2	M/2	Fulminating pneumonia	Antibiotics	Lack of supervision	Death	9	Fair;defensible
21	14,000	3/67	9/69	2+	M/64	Sigmoidoscopy	Surgery	Perforation	Carotid obstruction	4	Fair;nondefens
Without Attorney											
22	933	7/70	8/71	1	M/25	Back injury	Conservative treatment	Failure to operate	Delay in recovery	3	Large; defensible
23	1,750	9/70	5/71	< 1	F/56	Hysterectomy	Surgery	Vesico-vaginal fistula	Additional surgery	3	Fair;defensible
24	3,000	2/69	8/69	< 1	F/40	Urinary tract infection	Tests	Failure to observe enlarged cystic ovary	Delay in recovery	4	Large; defensible
25	3,000	5/70	10/71	1	M/48	Cut finger	Suture	Failure to diagnose severed tendon	Partial loss of use of finger	3	Fair;equivocal
26	1,500	3/71	71 - 72	< 1	M/adult	Ulcer	Surgery	Failure to diagnose bleeding spleen	Unknown	4	Fair;defensible
27	1,448	1971	6/71	< 1	M/39	Cataracts	Surgery	Poor result from eye surgery	Dissatisfaction	1	Nuisance; defensible
28	1,327	2/71	1/72	1	F/62	Bunion	Bunionectomy	Postoperative infection	Delay in recovery	1	Fair;defensible
29	4,480	1969	12/71	2	M/adult	Ulcerative colitis	Removal of rectal stump	Severed urethra	Additional surgery	2	Fair;defensible
30	10,000	8/66	10/69	3	F/20	D&C	Surgery	Postoperative infection; uterine fundus perforated	Hysterectomy	3	Fair;nondefens
31	1,000	1/70	8/71	1+	M/adult	Chest pain	Conservative treatment	Insufficient therapy	Anxiety	1	Nuisance; defensible
32	1,325	4/67	10/71	4+	M/61	Finger fracture	None	Delay in treatment	Delay in recovery	2	Fair;defensible
33	989	1/70	9/71	1+	F/<10	Foot injury	Bandage	Fail to diagnose fracture	Delay in recovery	2	Fair;nondefens
34	1,000	1968	6/71	3	M/adult	Back pain	Conservative treatment	Delay in surgery	Delay in recovery	3	Modest; defensible
35	9,500	3/68	2/70	2	F/52	Sore throat	Fiornal tablets	Failure to diagnose	Epidermoid carcinoma	4	Fair but low; nondefensible

The 32 Settled Cases by Years of Settlement

Table 2, shows the number of cases settled, and the amounts involved in each, for the calendar years from 1964 onward, for the 18 cases "settled with attorneys" and for the 14 cases "settled without attorneys", as follows:

Three of the 18 cases settled with attorneys were settled for sums much larger than the rest. No trend is apparent among these cases: a $65,000 settlement in 1966, a $32,175 settlement in 1967, and a $80,000 settlement in 1971. The largest of the remaining 15 settlements with which attorneys were involved occurred before 1968. During and after 1968 the largest settlements amounted to $5,000, $9,000, and $14,000 with the exception of the $80,000 settlement mentioned above. Thus, with respect to these non-large settlements, there does appear to be a tendency from larger settlements in the earlier years to smaller settlements in the later years.

Most all the settlements made "without plaintiff attorneys" were bunched in 1971, although two cases were settled without attorneys in 1969 and another in 1970. The explanation for the large increase in 1971 is a change in policy on the part of the Ross-Loos administration with respect to small settlements. On the basis of these few years, no trend in the amount of settlements is apparent, only the explosion of cases settled in 1971.

Whereas the average settlements of $18,671 for cases with attorney, and $2,940 for those without attorney seem to suggest a great difference in the amounts involved between the two groups, a comparison restricted to the years 1968 and following (excepting the large $80,000 settlement in 1971) narrows this difference appreciably. The eleven cases settled since 1968 with attorneys (excluding the $80,000 case) average $4,830 in contrast to the $2,940 average for those cases settled without attorneys.

The general time picture that emerges from this review is not entirely distinct. One senses a rhythm of one or two middling cases per year, with an avalanche of very minor cases in 1971, all against the backdrop of the four major settlements. The small cases make a semblance of great activity on the malpractice front but in Ross-Loos it is the big infrequent settlements (and the one judgment of 1965) that dominate the scene and account for most of the dollars.

Whether the total number of settlements is large in comparison with the nation is a question not easily

TABLE 2
ROSS-LOOS MEDICAL MALPRACTICE SETTLEMENTS, BY CALENDAR YEAR OF SETTLEMENT, FOR CASES SETTLED WITH AND WITHOUT ATTORNEYS.

Cases settled with attorneys			Cases settled without attorneys	
year	number of cases	indicated amounts of settlement in $	number of cases	indicated amounts of settlement in $
1964	2	17,500; 6,750	0	
1965 *	1	12,500	0	
1966	1	65,000	0	
1967	2	32,175; 10,000	0	
1968	5	9,000; 500; 1,800; 500; 2,500	0	
1969	2	2,500; 14,000	2	3,000; 10,000
1970	2	3,500; 5,000	1	9,500
1971	3	80,000; 1,500; 1,350	10	933; 1,750; 3,000 1,500; 1,448; 4,480 1,000; 1,325; 989; 1,000
1972	0		1	1,327
Total	18	$266,075 = $14,782/case	14	$41,252 = 2,940/case
"Non-large" Total	15			

*The $70,000 award made to a Ross-Loos plaintiff in 1965 was not included on the above Table, as it was the result of a judgment rather than a negotiated settlement.

answered. Since the membership of Ross-Loos is about 120,000 subscribers and dependents, the bracketed rate of from 2 to 4 settlements per year observed would project for a population of 200 million people a national rate of from 3,000 to 6,000 malpractice settlements per year. This projection does not appear to be too far out of line with the number observed in the survey of insurance company closed claims.[3] The Ross-Loos malpractice situation with respect to the total number of settlements thus does not appear to be out of line with the national average.

Severity of Injury

The severity of injury has been scored in accordance with the 9-point scale used in Bird Associates$_4$ report, "Alternatives to Medical Malpractice Litigation,"[4] and is indicated in Column 9 of Table 1 for each of the 35 cases. Table 3 shows the distribution of the scores for the 35 closed cases, as follows:

TABLE 3
SEVERITY OF INJURY AS SHOWN
IN 35 ROSS-LOOS CASES

Severity Scale	Arbitrated	Number of Cases Settled With Attorneys	Settled without Attorneys
1			3
2		3	3
3		1	5
4		6	3
5	1	3	
6		1	
7			
8			
9	2	4	
Total	3	18	14

The average severity of those cases settled without attorneys is between 2 and 3, whereas the average of those settled otherwise (excluding the deaths of category 9) is between 4 and 5. The low severity of those cases settled without attorneys illustrates over again that these were cases which may never have been pursued through the traditional tort litigation system. The average severity of the cases settled with attorneys is almost directly in line with that shown for the 438 cases observed in screening panels and actions at law.[5]

Defensible - Non Defensible Criteria

The medical legal reviewer scored each case on whether he considered it to be medically defensible or not. He considered a case to be non-defensible if negligence or a breach of duty were shown, or if the case in his judgment might find a verdict for the plaintiff because of jury sympathy. He scored the case as defensible if he felt that the verdict would likely be for the defense, were the case taken to action at law. In some cases he equivocated. Table 4 presents the information as scored for each of the 32 cases settled:

TABLE 4
DEFENSIBLE-NON DEFENSIBLE ASSESSMENT OF
32 ROSS-LOOS CASES

	Number of Cases	
	Settled with Attorneys	Settled without Attorneys
Defensible	5	10
Equivocal	3	1
Non-defensible	10	3
Total	18	14

Most of the cases settled without attorneys were thus scored as defensible, but were apparently considered by the Group to be not worth the cost or trouble of defending them. In contrast, most of the cases settled with attorneys were considered to be non-defensible. Among these non-defensible cases, of course, were the three big settlements of cases 4, 6, and 7.

Time Span in Settlement

Column five of Table 5 shows the time span in settlement for each of the 35 cases. The start date is usually the date of the first treatment as well as that of the alleged negligence. Some of the long intervals may arise when treatment was given prior to the alleged negligent act. Table 5 provides a frequency tabulation of the time intervals involved from first treatment or incident to settlement, as follows:

TABLE 5
TIME-SPAN FROM START DATE TO SETTLEMENT

Span in Years	Settled with Attorneys	Settled without Attorneys
less than 1	3	3
1 to 1.9	1	7
2 to 2.9	7	1
3 to 3.9	2	2
4 to 4.9	1	1
over 5	4	0
Total	18	14

---

[3] See "Medical Malpractice Insurance Claims Files Closed in 1970," *Supra,* pp. 1ff.

[4] See "Alternatives to Litigation, I: Technical Analysis," *Supra,* pp. 214ff.

[5] *Ibid.*

The median point of those cases settled without attorneys is about a year, whereas the median of those cases settled with attorneys is in the 2 to 2.9 year range. This bears out the notion that the many cases settled in 1971 without attorneys were settled quickly as well as for small amounts. For those cases settled with attorneys, closer examination of the basic data will show that the case interval seems to be decreasing, the longer intervals being for those cases before 1968.

The time interval of those cases settled with attorneys seems to be very much in line with the case intervals shown for the Pima and Maricopa County cases going to court decisions.[6] The shorter case intervals of those settled without attorneys seem to be more in line with the time intervals of the medical-legal panels.[7] The time intervals involved in the Ross-Loos closed cases settled with attorneys are thus neither outstandingly short nor long.

Age and sex of those involved in 35 cases

The ages and sex of those involved in the Ross-Loos cases shown no apparent departures from what might be expected.[8] The data are tabulated below for completeness and for possible reference to age patterns developed in other malpractice studies.

TABLE 6
AGE AND SEX IN 35 ROSS-LOOS CASES

Age in years	Male	Female	Total
0-9	1	2	3
10-19	0	1	1
20-29	2	2	4
30-39	1	1	2
40-49	3	2	5
50-59	4	4	8
60-69	3	2	5
Adult	4	1	5
	18	15	33
Unknown			2
Total			35

Conclusions

The conclusions and hypotheses drawn from this examination of the 35 closed cases are as follows:

1. Arbitration was involved in only one large judgment, that for $70,000 in 1965. The two other cases brought to arbitration in 1966 and in 1971 resulted in verdicts for the defendants. Thus, in experience, settlement between the parties has been favored 10 to 1 over the formal arbitration proceedings.
2. Three large settlements, all stemming from cases evaluated as probably non-defensible, were made for $65,000, $32,175, and $80,000 in 1966, 1967, and in 1971, respectively. These involved settlement time spans of 11, 12, and 4 years, respectively. Although the big years of settlements and judgments were 1965, 1966, 1967, and 1971, no trends among the big items are discernible.
3. The 15 smaller settlements made with attorneys, on the average about 2 per year, seem to be decreasing in time to settlement, and the cases on which they were based to be decreasing in defensibility. The aggregate of the 10 small settlements made after 1968 amount to less, usually much less, than any one of the large settlements.
4. The 14 settlements made without plaintiff attorneys are generally small in amount, low in severity of injury, quickly settled, and based on cases considered to be defensible. These came in significant volume only in 1971, and from the present data one cannot tell whether they will continue in this high volume or even increase in numbers. They are much like the small recent settlements made with attorneys. Their aggregate value is so small that they must be considered significant as an administrative policy change toward accommodating patients who may legitimately feel that they have been injured medically.
5. The number of malpractice settlements, the severity of the injuries, and the time span involved in those cases settled with attorneys show the malpractice situation at Ross-Loos not to be very different from that observed in the many other situations where malpractice cases are taken to medical legal panels or to actions at law.[9]

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[6] *Ibid.*

[7] *Ibid.*

[8] See "Medical Malpractice Insurance Claims Files Closed in 1970," *Supra,* pp. 1 ff.

[9] *Ibid.*

NON FAULT BASED MEDICAL INJURY COMPENSATION SYSTEMS

Edwin W. Roth
Paul Rosenthal

Summary

This study is directed toward an understanding of the ramifications of the non-fault-based medical injury compensation concept on the problems associated with medical malpractice, and assessing the potential impacts of implementing this concept. Included is a comparison of the non-fault-based concept with the current tort-liability approach to compensating the medically-injured.

An examination was made of the consequences of the tort-liability system on four segments of our society that are directly affected by the compensation problems associated with medical malpractice — (a) patient-claimants, (b) health care providers, (c) insurance carriers, and (d) the public-at-large. The conclusions drawn are that the medically injured are not being compensated in a timely and equitable manner and that the tort-liability system presents major deterrents to the improvement of health care services and the cost of medical services increases.

Non-fault-based medical injury compensation and the legal definition of medical malpractice are inconsistent. The concept of *strict liability* is substituted for negligence (fault) as a basis for recovery; that is, the complainant would be required to show only that he was *injured* while receiving medical care, without regard to whether someone was at fault or not.

The assessment of the alternative non-fault-based compensation system was based on the primary system characteristics of equitability, efficiency, cost, effectiveness and management. Each of the system characteristics has been associated with a number of system objectives which provide a meaningful operational framework for system assessment. The characteristics and related objectives are contained in Table 1 of the Report. The method used for comparing the alternative modes and, subsequently, comparing the recommended non-fault-based mode with the tort-liability system, is described in Section 4.

The recommended system consists of the following:

(1) All medical injury claims are handled within the recommended system.
(2) Claim initiation is the responsibility of the patient-claimant, with assistance provided by an impartial review process, and claim filing support from the Medical Injury Compensation Commission.
(3) Informal claim screening is compulsory. The resulting finding is not binding on the parties.
(4) Compensability determination is performed by a referee or a panel of referees, with awards limited to special damages.
(5) Appeals of findings are limited to mechanisms within the Medical Injury Compensation Commission. Appeals concerning procedure are resolved within the judicial framework.

The recommended non-fault-based compensation system, along with the suggested form of system funding appears to meet many of the objections to the tort-liability system for adjudicating medical malpractice claims. Since many of the legal concepts and administrative mechanisms of the recommended system are similar to the well-established Workmen's Compensation System, it would appear that the non-fault-based system could be acceptable. A model state law with associated commentary has been included in this Report.

Some important issues require exploration prior to full-scale implementation of the recommended system:

(1) The relationship between this compensation system and regulatory processes related to health care quality assurance.
(2) The accessibility of the courts to claimants for further recovery actions, given that the individual's

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compensation is limited to specific damages only.

(3) The expansion of sources of system funding to include the recipients of health care services and/or the general public.

(4) The optimal organizational structures for administering and operating the non-fault-based compensation system.

The study recommends that these explorations be performed within a number of Federally-sponsored demonstration projects to provide the needed information and a sound base for the individual states in enacting a non-fault-based medical injury compensation system.

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1. Introduction

STUDY PURPOSE

This study is concerned with the derivation of a better understanding of the ramifications of the non-fault-based medical injury compensation concept on the problems associated with malpractice, and assessing the potential impacts of implementing this concept. Included within the impact assessment is a comparison of the non-fault-based concept with the current tort-liability approach to compensating the medically-injured.

The non-fault-based concept can take-on many forms or "modes". For example, it can deal solely with compensation which is limited to special damages (e.g. costs incurred, future costs, and loss of income), or it can encompass both special and general damages (e.g. pain and suffering, loss of consortium). It can also include a mandatory claim screening mechanism or allow all claims to be processed directly within a compensation determination body. Also, a variety of approaches can be introduced for assisting in the claim initiation process. These items are but a few of the many system elements that may vary within a non-fault-based medical injury compensation system (to be referred to on occasion within the Report as a non-fault-based system).

The major question to be addressed is whether any of the alternative modes into which the non-fault-based system can be cast, constitute an acceptable replacement for the existing fault-based compensation system. *Thus, the purpose of this Study is to define and evaluate alternative non-fault-based medical injury compensation modes, and to recommend an acceptable non-fault-based system.*

STUDY APPROACH

Overview

Our overall approach to the study of the feasibility of a non-fault-based medical injury compensation system involves an assessment of the alternative non-fault-based schemes which have been proposed along with those modes which have been designed by our study team. The assessment of each mode is made relative to such objectives as consistency of decisions and awards; promptness of compensation; recovery of direct and total losses; efficiency of the system, that is minimizing duplication and overhead; and such management objectives as accountability and system improvement. At this stage, in part because of the paucity of available data, the comparison of the alternative modes has been made on a relative basis and the form of the outputs are both quantitative and judgmental.

In keeping with the above, our review of the literature has covered the spectrum of non-fault-based compensation systems—ranging from various workmen's compensation to automobile injury compensation schemes, within and outside the United States. This review has enabled us to design a spectrum of alternative non-fault-based compensation modes for subsequent evaluation. Based on the criteria mentioned above, as well as others, described in Section 3 of this Report, the modes are evaluated and ranked. Lastly, a model state law that is adaptable to the specific needs of any state has been prepared, based on the underlying concept and the recommended non-fault-based mode. Thus, the main outputs of this study are: (1) the evaluated impact of a wide spectrum of non-fault-based compensation modes, (2) the recommended non-fault-based medical injury compensation system, and (3) a model-law developed around the most suitable mode.

We fully recognize that this brief but concentrated investigation has only addressed the question of the feasiblity of the mode which appears to possess greatest promise, and the directions which should be taken by State legislatures in introducing non-fault-based medical injury compensation provisions. A further stage of evaluation and validation would be the establishment of one or several demonstration programs. This is contained in our recommendations.

Alternative Non-Fault-Based Medical Injury Compensation Modes

In recognition of the large number of potential alternative non-fault-based modes many of which are rather similar in their characteristics, a taxonomy has been developed which is responsive to both the objectives of the overall study as well as to the evaluation model for assessing the alternative modes. Such a classification scheme has assisted in reviewing the available literature, enhancing the design process of alternative non-fault-based modes, and in performing the assessment and presentation of results of the various alternatives. The development of such a taxonomy has been derived, in large measure, from the interactive efforts of the literature review, the model development and the nature of the research products. In the instance of the literature review, we asked the questions—What should we be looking for and conversely, What information is available for structuring the categorization schema? In the case of the evaluation model, How gross or detailed should the model structure be so that the outputs are sensitive to changes in parametric values, and what levels of mode disaggregation are required to permit mode differences to be estimated? Finally, What detailed level of alternative mode specifications is useful, and how should the classification scheme be structured to permit the appropriate level(s) of disaggregation?

The structure of the taxonomy consists of three basic levels—concepts, elements and forms.

The first level, concepts, relates to the underlying philosophy of compensation upon which the system is constructed. The current tort-liability approach to compensating the medically-injured contains thefundamental issues of (1) the failure of the health provider to perform his duty, and (2) the patient experiencing a definite injury as a result of that failure. Within the Workmen's Compensation System, the basis of compensation is founded on the principle of strict liability. Here, the complainant (employee) merely shows that he was injured while at his place of employment, and in certain instances, during the course of employment, to be eligible for recovery. Another concept upon which a compensation system could be established is the societal responsibility to reduce the losses experienced by anyone who is injured or becomes ill, regardless of the cause. The concepts, as directly related to the non-fault-based medical injury compensation problem have been stated in broad terms so as to allow for a number of alternative modes to be designed which are consistent with the inherent philosophy embedded within the concept.

By elements we mean the individual portions or properties of the compensation system which can include process, organizational and administrative considerations. Examples of elements include (1) selection of compensation system, (2) claim initiation, (3) claim screening, (4) determination of compensability, and (5) appeal. The intent of specifying elements is to structure the description of an already introduced concept as located within the extant literature or practice, and/or to introduce significant variations of the concept.

Lastly, the third level, alternative forms, is related directly to individual elements and consists of specific descriptions of the individual elements. Thus, within a concept, and using the alternative forms associated with individual elements, it is now possible to describe compensation modes which can be examined for their medico-legal validity and can be assessed within the evaluation structure. Within the design of alternative modes we specify, for example, the compensable injury or injuries, the mechanism for compensation determination (peer panel, compensation committee, expert panel, etc.), financial participants (practitioners, health care recipients, government), claim initiators (patient, provider, third party), appeal process, etc. These descriptions are sufficiently complete so as to enable an analysis of the modes, and to make judgmental determinations on such issues as: (1) the future role of the tort-liability system for medical-injury adjudication purposes and (2) the required mechanisms for maintaining quality of health care.

This approach to mode identification and description has been employed so as to insure that a broad spectrum of alternatives receives some assessment prior to the reduction and examination of a more limited set of modes. Additionally, it is believed that this approach insures that the specified modes are detailed sufficiently and are logically consistent. Based on the results derived from the assessment of the alternative modes, and the underlying concept, a model law has been prepared. Lastly, this framework, within which the alternative modes were designed, has been of assistance to the Commission Staff in its review of the modes prior to the initiation of the more detailed evaluation stage of the study.

Alternative Mode Evaluation and Recommendations

The previous discussion set forth the notion of concept/mode couples, defining in effect, a particular non-fault-based medical injury compensation system structure. Clearly one can envisage an extremely large set of concept/mode couples and, consequently, an inordinately large task of having to model, evaluate and compare a large number of non-fault-based modes. With a specified taxonomy, and in recognition of the limited available data, a manageable and "most relevant" set of candidate concept/modes was delineated with the use of relevant judgment. As noted above, the set of modes were submitted to the Commission Staff for review and suggested modification.

The methodology employed in evaluating the alternative modes involved devising an evaluation model framework within which the alternative non-fault-based system structures were assessed, along with a qualitative/quantitative evaluation based on the judgment of the project team, and the medical and legal consultants. Fig. 2 depicts the modeling framework employed in analyzing the alternative non-fault-based modes. The essential components are the *inputs* to the non-fault-based system, the *operational and administrative structure* of the non-fault-based system being analyzed, and the *outputs* resulting from the non-fault-based system.

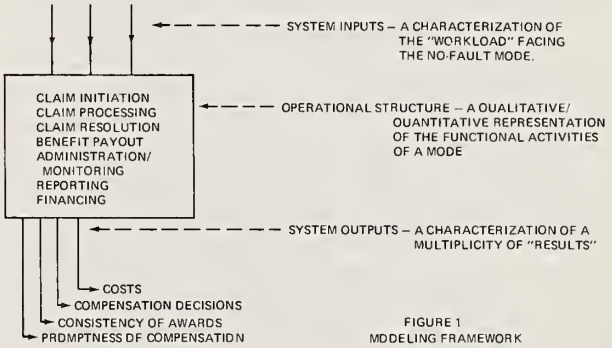
SYSTEM INPUTS – A CHARACTERIZATION OF THE "WORKLOAD" FACING THE NO-FAULT MODE.
CLAIM INITIATION
CLAIM PROCESSING
CLAIM RESOLUTION
BENEFIT PAYOUT
ADMINISTRATION/ MONITORING
REPORTING
FINANCING
OPERATIONAL STRUCTURE – A QUALITATIVE/ QUANTITATIVE REPRESENTATION OF THE FUNCTIONAL ACTIVITIES OF A MODE
SYSTEM OUTPUTS – A CHARACTERIZATION OF A MULTIPLICITY OF "RESULTS"
COSTS
COMPENSATION DECISIONS
CONSISTENCY OF AWARDS
PROMPTNESS OF COMPENSATION
FIGURE 1
MODELING FRAMEWORK

FIGURE 1
MODELING FRAMEWORK

The SYSTEM inputs for the non-fault-based mode being analyzed are characterized by an appropriate set of attributes which adequately describes such entities as the volumes and types of compensable injuries to be handled by the mode, and a delineation of how and by whom claims are initiated. In short, the inputs describe the type and magnitude of claims entering the system and the conditions whereby they are brought to the attention of the administrative mechanism.

The OPERATIONAL AND ADMINISTRATIVE STRUCTURE of the non-fault-based mode being analyzed includes those essential organizational and operational elements which determine how and to what level the costs of operating the mode arise, what administrative structure and mechanisms are employed, and how and to what extent the non-fault-based structure may interface with the tort-liability system. Our general approach to the analysis model has been to consider the costs attributable to each of the major elements of the mode. An initial list of generic elements and mode characteristics is as follows: claim initiation, claim processing, claim resolution, benefit payout, administration/monitoring of the mode, reporting to authorities, and financing.

The SYSTEM OUTPUTS play a key role in facilitating the assessment of an individual non-fault-based mode, as well as the comparison among alternative modes. A set of output types is delineated which constitute those segments of the model framework which all candidate structures have in common, even though the system inputs and/or operational structures are not identical. The major output type is the benefits which, under a particular mode, are associated with the health care provider, the patients, etc. These outputs are of a qualitative nature, e.g. equitability, efficiency, effectiveness, etc. The outputs are then employed in performing a qualitative/quantitative comparison of the benefits associated with the alternative modes. Based on these results, a concept/mode has been recommended for use in drafting the model law.

Model Law

The model law delineates those major organizational, structural, and operational characteristics which should be provided for in any piece of legislation drafted at the state level. The characteristics delineated result from the analyses and evaluations performed on the alternate non-fault-based modes and the recommended mode. The manner in which they are phrased was carefully drafted in concert with the legal consultants on the project team. This has been performed so that the end product retains the comprehensiveness and structural completeness necessary to assure the operational characteristics desired, and yet is presented in a manner which provides a useful starting point to the legislative draftsman in any given state. The model law is sufficiently comprehensive so that no essential provision is overlooked. The provisions are written with the degree of specificity consistent with available knowledge on the costs and effects. A lack of specificity in the model law might lead to arbitrary specifications in the state's bill, or may lead to lack of specificity in the state's bill and the latter may lead to misinterpretations by those who must administer the law.

CONSTRAINTS AND LIMITATIONS

The performance of a study of non-fault-based medical injury compensation within a three month period is fraught with difficulties and necessitated the making of numerous decisions affecting the comprehensiveness and detail of the examinations and analyses being undertaken.

First and foremost, the focus of the research is on non-fault-based medical injury compensation schemes rather than more far-reaching consideration of all alternatives to the current fault-liability approach. Although some assessment was made of the tort-liability system for compensating the medically-injured, in terms of its advantages and limitations, as well as a conceptualized social security insurance scheme, it was done primarily for making comparative evaluations with the non-fault-based system. Thus, it can not be asserted that a detailed and conclusive analysis has been made of the absolute merit of the non-fault-based alternative or other compensation systems.

Secondly, this study effort has been almost entirely dependent on the commission-sponsored data collection and analysis projects to provide detailed information pertaining to the magnitude of the incidents of medical injuries; the frequency and types of incurred medical injuries; the actions taken by patients who have been injured; the disposition of claims and suits by the insurance carriers; and the experience and behavior of attorneys relative to handling potential malpractice incidents. Only limited and fragmentary date were available to this study effort during the period of investigation.

Lastly, and of prime significance, it should be well-recognized that the subject of examining alternative schemes for compensating the medically-injured is exceedingly complex since it entails some basic social policy issues along with the highly interrelated issue of providing high quality and cost-beneficial health services to all people. Fundamental questions requiring resolution are: (a) Does society have a responsibility toward the injured and if yes, to what degree? (b) How would the implementation of a new compensation system (e.g. non-fault-based) affect the delivery of health services? (c) What would be the impact of the proposed alternative compensation system on the health care providers and institutions, the legal profession, insurance carriers and the public-at-large? (d) What are the ligitimate roles and responsibilities of the Federal and State governments? (e) Can we afford and are we willing to fund this potentially more expensive medical-injury compensation system? Providing answers to the majority of these questions was well beyond the limitations of this study although the issues were dealt with to a limited extent during the concept formulation, selection, and the design of alternative non-fault-based medical injury compensation mode-stages of the study.

Within these constraints and limitations in terms of scope, time and data, the study was performed, conclusions drawn, and recommendations made. A greater reliance was placed on informed judgment and experience, which was obtained from the literature, and from professionals within the medical, legal and insurance communities than was planned for during the design of the study effort. However, even under the best of conditions, that is, the elimination of the constraints and limitations as noted above, the true test and evaluation of any recommended compensation system must await the verdict of all the affected parties. Thus, it is desirable, if not mandatory, to establish one or several demonstration programs so as to measure and evaluate the impact of the compensation system on both a comparative basis (with the current fault-liability approach) as well as on a more absolute basis.

2. Current and Proposed Methods for Compensating the Medically Injured

INTRODUCTION

Over the past several years growing concern with the current tort-liability approach, for compensating the medically-injured has been expressed. In response to the perceived limitations and difficulties encountered with the current method, a variety of alternatives has been formulated and in some instances implemented. Some of the factors underlying this concern, and the bases of the various alternatives being examined are the:

- Rapidly growing number of malpractice claims and magnitude of awards,
- Increasing social awareness of, and responsibility for the plight of medically-injured,
- Changing institutional and professional forms of health care delivery, and
- Emerging willingness of health care providers, insurance carriers, attorneys and public to utilize various compensation approaches which appear more efficacious and which ameliorate some of the perceived shortcomings of the fault-liability approach.

It is accepted by health care providers and institutions that, in the course of delivering health services on a large scale, a small percentage of patients will be injured. The injuries may be the result of accident, negligence or the risks statistically associated with almost all treatment. Major efforts are being made to reduce the number of injuries through better training, closer supervision and tighter regulation of health care delivery; all within the recognition that medical injuries can not be eliminated completely. Although the current method of compensating the medically-injured serves in some degree to reduce the number of injuries, this is not the expressed objective of the "system". Thus, given that injuries will be experienced by patients during medical intervention, it is incumbent on the health care providers and institutions to institute steps to minimize these injuries, and at the same time, it is the responsibility of society to formulate, analyze and implement compensation systems which most appropriately deal with the problems encountered by a patient who incurs a medical injury.

THE NON-EXISTENCE OF A SYSTEM FOR MEDICAL-INJURY COMPENSATION

The fault-liability approach to the compensation of the medically-injured consists of a series of loosely-related processes which, when appropriately employed by the patient-complainant, assists him in receiving a monetary award/settlement given that his injury is adjudged compensable. First, with little or no assistance, the patient must recognize that he has incurred a medically-induced injury. Second, he must locate an attorney who is willing to accept him as a client and to pursue the claim in an effective manner. Last, he is confronted by the vagaries of our trial by jury system in its decision-making process, that it, the unsystematic means for determining that the injury is compensable, and establishing a just award for the claimant. There are strong indications, as noted in both the (Commission-sponsored) Consumer Survey and Legal Systems Study that the first and second conditions, cited above, present major impediments to the patient-claimant in pursuing his quest for compensation. In particular, if the size of the claimed damage or loss is small, that is, of the order of several thousand dollars or less, or if there is reasonable uncertainty regarding the outcome, the claimant has significant difficulty in securing competent legal assistance. Also, there are major differences in attitudes, laws, and court decisions throughout the United States (even within a single state) concerning medical malpractice claims. These differences yield substantial variations in compensation awards (or non-awards) for similar injuries and related conditions.

Beyond these problems confronting the claimant, it should be recognized that the legal processes for providing remedy to the patient-claimant cannot be viewed as constituting an actual system of compensation because of the following:

(1) Whereas the outcome of a system can be predicted within statistical limits, predictability is almost non-existent within the tort approach. Except for the introduction of legal opinions from prior cases, there are no systematized schemes within the fault-liability approach pertinent to the issues of award determination and the amount of award. The sizes of awards can be dramatically different for a similar injury and its associated conditions within the same jurisdiction, and has been found to vary substantially among different geographical locations.

(2) Through feedback mechanisms, systems evolve in form and performance so as to achieve their objectives and operate in the most effective manner. However, within the fault-liability approach to compensation, the results of litigation, and settlements and awards are not systematically collected and disseminated to the insurance industry, the health care providers and institutions, and the public-at-large.

In both instances, the capabilities for true system improvement are missing, and the fault-liability approach has not provided the health care practitioners and institutions with the underlying legal doctrines which are applicable in the determination of medical malpractice and compensable medical injuries.

To classify a compensation mechanism as a system, it should, (1) embody a systematized series of procedures/stages within a well-defined organization and administrative structure, (2) incorporate the capabilities for self-improvement and (3) provide assistance in the alleviating of those conditions responsible, in whole or in part, for the existence of the particular problem. In considering the fault-liability approach for compensating the medically-injured, it is located and manned (attorneys, judges, juries, etc.) within a much broader legal context—civil law, with little or no consideration given to the broad systemic health care delivery issues giving rise to the basic problems. In fairness to this approach to compensation, it should be said that many of the system elements are present or can be introduced, but as it currently exists, the approach does not meet the requirements of a system.[1]

Other approaches to the compensation problem have been suggested, such as arbitration, trip insurance, and claim screening, but when examined within the framework of the requisite characteristics of a compensation system, they represent partial solutions at a system of compensation. Arbitration is primarily an adjudication alternative to the courts; trip insurance is an alternative funding scheme; and claim screening is an approach to discourage or eliminate nonmeritorious claims and to assist meritorious claims, in some applications.

A partial, although significant explanation, of the nonexistence of a system is the separation of the health care delivery system from the medical-injury compensation system. As noted by Rick Carlson[2] one of the significant output measures which should be used by the health care providers for improving the quality of health care is reported medical malpractice (by types and quantities). However, what is being used by the practitioners and institutions are such process measures as peer review, tissue committees, utilization review, etc.; all of which are directly under the purview of the health care providers and institutions. Whereas the patient care results (or outcomes), as partially measured by the types and magnitudes of malpractice suits and dispositions, can play a major role in alleviating the conditions giving rise to medical injuries, they are not systematically collected and/or utilized.

It is within the explanation of what constitutes a system for compensating the medically-injured and the advantage of establishing a close coupling between the compensation system and the health care system, that the discussion of the current fault-liability and methods for compensation is presented.

FAULT-LIABILITY (TORT) APPROACH

Many discussions of the fault-liability approach for compensating the medically-injured focus on its major deficiencies and limitations, and provide only passing comment on several of its advantages. So as to present a more balanced viewpoint for assessing this approach relative to others, such as the non-fault-based medical injury compensation system, explicit discussion of the advantages of the fault-liability approach is contained herein.

The fault-liability approach has been an integral part of Anglo-American law and thus represents a tried and tested method for adjudicating conflicting civil claims and determining awards. Over the many years the approach has been refined through judicial opinions and administrative procedures. Inherent within the approach is a body of codified procedures and precedents for conducting trials and hearings. It is this experience and knowledge derived from the "known" that gives the fault-liability approach its strength when considering the substitution of an alternate method of compensation.

Closely related to society's long standing familiarity and dependence on the tort system, is the principle of peer judgments. It has been argued that although there are many shortcomings with the jury concept, there is no satisfactory alternative. Since the issue of compensating the medically-injured involves placing monetary values on such non-monetary damages as pain and suffering and loss of consortium, the judgments of a peer group appear almost indispensable in making this determination. Furthermore, it is argued that the collective wisdom of a jury provides a strong capability for identifying fraud and exaggeration. It should be noted that the validity of these assertions is difficult to measure objectively.

It has been alleged, and the practice of defensive medicine[3] is provided as supportive evidence, that the stigma and emotional distress to the health care practitioners of having a malpractice suit adjudicated in court has improved the quality of health care delivery. The increasing frequency of malpractice suits has introduced a higher degree of concern with the thoroughness of health care delivery than would exist if this form of compensation system was abandoned for one that is operated within a "less publicized" arena. It cannot be concluded at this time that the quality of health care would be lessened significantly and would be delivered in a more cost-effective basis, if the fault-liability approach was abandoned in favor of a "fault-free" compensation system. What is meant here is that many of the defensive medical tests, procedures and treatments may be used more sparingly with albeit the introduction of a very slightly increased risk to the patient population. As noted in the Commission report related to defensive medicine[4], although the specific tests and treatments associated with defensive medicine are difficult to delineate, there is wide-spread acknowledgement that the phenomenon exists and is practiced generally. Furthermore, although the medical utility of defensive medicine may be minimal, it has on rare occasions proven useful in the diagnostic process. The underlying motivation for the application of defensive medicine is the potential malpractice law suit and the concern that the involved health providers would be discredited if they had not performed a particular test or procedure no matter how remote its potential value in treating the specific disease or patient.

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[1] Although it has been shown here that the tort-liability approach is not a "system" in the formal sense, it is referred to as a system within the following sections of this Report for convenience.

[2] Rick J. Carlson, "The Feasibility of a No-Fault Compensation System for Medical Injuries." The Institute for Interdisciplinary Studies, Minneapolis, Minn. (Unpublished paper).

[3] As usually defined, "defensive medicine" includes both the employment of tests and procedures that are not strictly necessary, and the avoidance of innovative or less customary procedures. The term as used here denotes only the former type of medical practice.

[4] See "Defensive Medicine," *Supra*, pp. 38ff.

retaining the current system (e.g., provide a motivation for improving health care delivery), with possibly some minor modifications, the tort-liability approach presents some serious problems to the deliverers of health care services and to the medically-injured. The initiation of a malpractice claim within this approach often results in a damaging adversary relationship between patient and health care provider. The affected parties along with the insurance carrier are in agreement that prompt and consistent resolutions of disputes are difficult to achieve within this approach. Although reduced costs of litigation and insurance are viewed highly desirable by all groups involved, they probably cannot be achieved within the fault-liability approach. Therefore, there is a general argument that an alternative compensation system which removes these significant disadvantages is desirable.

In addition to the generally accepted deficiencies of the fault-liability approach to the medical malpractice compensation issue are the differential effects experienced by four segments directly involved with the health care system—(A) patient-claimant, (B) health-care provider, (C) insurance carrier, and (D) public-at-large. The following is a summary of various major deleterious consequences which are alleged to result from the present fault-liability approach of resolving malpractice grievances:

A. *Patient-Claimant*
  - Difficulty in uncovering medical evidence to prove provider negligence
  - High cost of pursuing claims through legal channels thereby requiring the payment of large attorney fees (high contingency fee percentage and expenses) in the event of favorable disposition
  - Difficulty in obtaining competent legal assistance for relatively minor claims thereby discouraging their filing
  - Ambivalence in subjecting health care provider to stigma and adverse publicity
  - Large disparity of awards and settlements for comparable injuries and circumstances
  - Induces the patient-claimant to exaggeration and fraud.

B. *Health-Care Provider*
  - Long delays cause anxiety as to outcome of claims
  - Negative reflection on professional stature
  - Impedes the willingness to apply new techniques in favor of tried and proven procedures
  - Degrades the relationship with patient by introducing suspicion and hostility
  - Encourages practice of defensive medicine
  - Results in loss of time from practice in preparing for defense.

C. *Insurance Carrier*
  - Incurs large administrative costs
  - Presents difficulties in setting actuarially-sound rates because of low predictability of number of claims and their dispositions, and size of settlements and awards.

D. *Public-at-Large*
  - Increases cost of health care as a result of the alleged practice of defensive medicine and need to offset high malpractice insurance costs of health care providers and institutions
  - Delays introduction of improvements in the delivery of health care services because of threat of malpractice claims as perceived by health care providers.

In view of the deficiencies associated with the fault-liability approach which are experienced uniformly by the patient-claimant, health-care provider, insurance carrier and the public-at-large, as well as those felt differentially by the individual groups, as indicated above, there has been and is a desire to implement alternatives to compensate the medically-injured. These alternatives range from minor tinkering with judicial procedures to the introduction of a total social security insurance program for compensating all individuals experiencing any form of medical problem. The decision as to the particular alternative, assuming some change to the fault-liability approach is made at the state level, will be heavily influenced by the perceived needs and mood of the citizenry.

ALTERNATIVE COMPENSATION APPROACHES AND PROCEDURES

Social Security Insurance Approach

If one were to establish a continuum of compensation alternatives, the fault-liability approach would be placed near one end of the spectrum with the social security insurance approach located at the other end of the scale. The wide disparity between these approaches is embedded in their underlying social philosophies. On the one hand the fault-liability approach, with its many barriers to compensating the patient-complainant, places the burden of proof and discovery on the plaintiff in establishing that the health care provider did not properly perform his legal duties in his professional relationship to his patient and that definite injury resulted from that failure. The social security insurance approach is premised on the principle that it is in the national interest and a national obligation to provide for all citizens who sustain injury and to alleviate the burden of individual loss for those individuals whose ability to contribute to the general welfare has been interrupted. In its broadest interpretation, this principle subsumes *all* forms of incapacitation including sickness as well as injury (medically-associated, work-related, and non-work-related), whether the individual is part of the work force or not.

Within the context of a medical injury compensation approach, the interpretation of this principle could be limited to those injuries or outcomes which affect the individual's ability to contribute to the general welfare and suffer losses. As stated within the report of the New Zealand Royal Commission of Inquiry[5], a unified and comprehensive system for meeting the losses which arise from personal injury would cover the individual no matter where or how the injury might occur. Further, a broad compensation system would provide income-related benefits over the total period of incapacity regardless of whether or not the bodily impairment affects the earning capacity of the individual.

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[5] See "No-Fault Compensation for Personal Injury in New Zealand," *Infra*, pp. 836ff.

Thus, the compensation of the individual would depend on his degree of incapacitation and resulting losses and would not require the tortuous process of establishing fault and medical causation. The adoption of such a system of compensation would remove the financial burden from the unfortunate individual and would spread the risk over the entire society. The problems associated with administering, financing and establishing of compensation levels are discussed within the Royal Commission Report. The final recommendation of the New Zealand Parliament was for a far less comprehensive compensation system.

Trip Insurance

Professor Ehrenzweig[6] and several others have suggested a first-party insurance plan for providing at least partial funding for compensating the medically-injured patient. Here again, although this funding procedure can take a variety of forms, its utility can only be assessed when considered within a specific compensation system. However, the proponents of such a funding scheme argue that since the patient pays for the health care provider's professional liability insurance, it is to his advantage to obtain the direct services of the insurance carrier compensation in obtaining settlement or compensation for his claim. It would then be the responsibility of the insurance carrier to subrogate the monetary settlement with the health provider's insurance carrier. By having the patient carry his own insurance, some of the patient-health care provider stresses resulting from the adversary encounter could be reduced.

Two potential disadvantages associated with "trip insurance" are both related to cost. First, because of the attendent administrative costs of this type of insurance, the cost for the coverage purchased is expected to be rather high as compared to the patient's pro rata share of the health-care provider's premium. Secondly, given that the health care-provider still maintains professional liability insurance to cover himself against those patients who file claims and/or for subrogation purposes, the total cost of insurance to the patient will be higher.

Health, Life and Disability Insurance

Large segments of the American population are currently included within a variety of insurance plans which provide them and their dependents with compensation against losses resulting from medical injury and death. For example, where there is a delay in health recovery due to a hospital-incurred medical misadventure, the patient who carries health insurance is normally compensated for any additional hospital and medical expenses by his medical and hospital insurance. In the event of death, the patient's life insurance would provide payment to his survivors. Where permanent disability results, those patients included within the Social Security Program would receive disability payments. Thus, a large portion of the medically-injured population has one or several types of insurance coverage to ease some of the financial burden associated with some forms of medical injury.

When the patient-claimant employs the fault-liability approach to obtain compensation for an injury he alleges to have incurred, the existence of other sources of monetary recovery is not considered in the establishment of the award. Under this circumstance, the patient may and normally does receive multiple compensation for the same losses, such as hospital, medical and drug expenses. The occurrence of multiple payments by several insurance and compensation programs results in an increased expense to these programs and ultimately to the individuals covered within these insurance programs.

SYNTHESIS

The foregoing discussion of the current and alternative approaches to the medical composition problem has highlighted the fact that a *system* for compensating the medically-insured does not exist at this time. However, if the properties associated with the definition of a system were relaxed, that is, the conditions for feed-back and systematic self correction, then the fault-liability approach could qualify as a system. Additionally, it may be appropriate to include the social security insurance approach as a system of compensation.

The focus of the reported study, the non-fault-based medical injury compensation system, as defined within Section 5 has all the properties of a system. Thus, the following examination and assessment of this form of a compensation system will, in part, be made by comparing its characteristics with those incorporated within the fault-liability and the social security insurance systems. Since the latter system has not been well-defined, in terms of its administrative structure, operational procedures and funding mechanisms, some of the statements made when comparing it to the non-fault-based system are based on general principles and its analogy with the current U.S. Social Security Program.

Finally, the other approaches mentioned—arbitration, claim screening and trip insurance-have been considered and incorporated to varying degrees in the formulation and design of the alternative no-fault-based compensation modes.

3.Non-Fault-Based Medical Injury Compensation System

METHODOLOGICAL OVERVIEW OF MODE DESIGN AND EVALUATION

A non-fault-based compensation system within the legal definition of medical malpractice is patently contradictory. The primary purpose of a medical injury compensation system should be providing appropriate remedy to patient-claimants who are medically injured rather than focusing on the specific acts of commission and/or omission of identified health care practitioners who are allegedly responsible for the injury. The degree to which this purpose is accepted and implemented within the proposed system can have a significant effect on health care delivery.

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[6] Ehrenzweig, Albert A., Compulsory Health Accident Insurance - A Needed First Step Toward The Displacement of Liability For Medical Malpractice, *31 U. of Chicago Law Review,* Rev. 279, 1964.

A number of definitions of compensable medical injury have been considered. Of particular interest has been a class of definitions premised on the notion that compensability should be based on determining whether or not the outcome of medical intervention is significantly poorer than the normally expected outcome. It was concluded, however, that information currently available for implementing a compensation system based on such a definition is insufficient. These outcome models of medical injury and other medical injury definitions are discussed in Appendix A and the compensable injury definition finally incorporated in the proposed system is described in detail in this Section.

The underlying legal concept of the proposed injury definition is founded on strict liability. This means that in general, given that an individual incurs a medical injury during the course of medical care, he will receive compensation without having to identify the specific act, treatment or any cause, and certainly without having to establish any negligent act on the part of a health care provider and/or institution. The formulation, evaluation and recommendation of an appropriate non-fault-based medical injury compensation system from this concept involves a logical and systematic process. Characteristics and objectives against which candidate compensation systems can be evaluated must be formulated.

From this basic non-fault-based concept, the definition of compensable medical injury and the system characteristics and objectives, a series of feasible and administrable non-fault-based modes are formulated. The alternative modes are constructed from a set of system elements, some of which have more than one form. Since the number of modes derived from the combinatorial process is very large, a judgmental method of mode assessment is utilized so as to eliminate those alternative modes which are either logically, operationally or administratively deficient. The modes which survive this process are evaluated relative to a set of system objectives and finally, that mode (the recommended system) which has the highest values across the system characteristics of equitability, efficiency, cost, effectiveness and management is described in somewhat greater detail so as to form the basis of the "model law".

NON-FAULT-BASED INJURY COMPENSATION SYSTEM CONCEPT

The design of the non-fault-based medical injury compensation system has been heavily influenced by two central requirements:

(1) the recommended system must encompass all medical injuries which are compensable under the present tort-liability system.

(2) the system structures must be set up in a manner which accommodates the specification of a number of modes, whose effect on system objectives or performance can then be compared and evaluated.

The system concept and design, described herein, meets both requirements. The underlying definition of compensable injury includes injuries compensable under the tort-liability system; furthermore, the definition permits controlled and selected variations in the compensability criteria as well as in the amounts of compensation.

The concept can be described in broad terms as one of compensation for medical injury without establishment of fault and administered by a (quasi-governmental) Medical Injury Compensation Commission.

Governmental administration of the Commission is recommended to assure reliability, consistency, and equitability of operation. Such a Commission permits wide variation as to provisions for fact-finding, decision-making and appeal. Moreover, such a Commission while tending to assure consistency of the compensation process, is compatible with the desirable retention of private insurance carriers for the collection of premiums from health care providers and patients, and the payment of compensation to claimants. The Commission has the responsibility for policy setting, and determining compensability and compensation practices in consonance with the legislation establishing the non-fault-based system. Representatives of the health provider, legal, insurance and recipient communities would serve on this policy-making body. This scope of representation is particularly important in view of the future changes in health care delivery, perceived evolutionary nature of non-fault-based medical injury compensation, and the broad range of technical issues and social policy questions to be examined.

In addition, such a system would incorporate the requirement that a written record be produced for each claim. The cumulative record may serve to guide the Medical Injury Compensation Commission in refining rules of compensability; setting damage schedules; determining actuarially-sound bases for insurance premiums and reporting aggregated information to agencies concerned with the quality of health care. The creation of the Medical Injury Compensation Commission, as implied by this requirement, will make possible an evolutionary progression from subjective, individual evaluation of each claim toward objective, systematic evaluation based on established measures, criteria and schedules.

Unlike the Keeton-O'Connell recommendation for no-fault-compensation associated with automobile injuries, all medical injury claims, regardless of size, would be included within the recommended system. This position appears valid since the effect of large claims, and corresponding large awards, on insurance premiums constitute a significant part of the malpractice "problem" when adjudication of such claims is made within the unpredictable tort-liability system. Provision for access to the court when claims are large would thus work counter to the purpose of establishing a non-fault-based injury compensation system. Moreover, by including all claims, greater consistency and predictability in amounts awarded should be achieved.

It does not appear economically prudent to allow the medical injury compensation system to pay for losses which are already covered by other forms of health, liability or social security insurance. As in the New York State Workmen's Compensation System, medical injury insurance would provide payment only to the extent of losses not compensated by such other sources as Blue Cross and Blue Shield, Medicare, Social Security, etc. Therefore, the recommended concept includes provision for a no-collateral-source rule.

At this point, it is necessary to introduce the underlying legal concept which appears appropriate for the non-fault-based system and then provide an administratively-feasible definition of compensable injury. Within a non-fault-based system, the concept of *strict liability* would be substituted for negligence (fault) as the basis for recovery; the complainant would merely show that he was injured through a "medical intervention accident". Thus the application of strict liability would be the basis for recovery in instances where a person has been injured during medical intervention whether someone was at fault or not. Justice Tobriner in the California Supreme Court case of *Clark v. Gibbons*[7] stated: "If public policy demands that defendants be held responsible for unexplained accidents without a reasoned finding of fault, such responsibility should be fixed openly and uniformly, not under the guise of negligence and at the discretion of a jury." The classic and analogous application of the strict liability concept is the Workmen's Compensation System. A further argument in support of the introduction of this concept is that personal injury is no less painful, disabling, costly or damage-producing simply because the harm is inflicted by an unavoidable accident rather than by someone's negligence.

Paramount in the design of the compensation system is the specification of those classes of injuries which would be compensable. After considerable research and deliberation, the following definition is proposed.

> A *compensable injury* is defined as any physical harm, bodily impairment, disfigurement, or delay in recovery which (i) is more probably associated in whole or in part with medical intervention rather than with the condition for which such intervention occurred, and (ii) is not consistent with or reasonably to be expected as a consequence of such intervention or (iii) is a result of medical intervention to which the patient has not given his informed consent.

Included within this offered definition are all medical injury situations which are currently compensated within the tort-liability system as well as a class of medical injuries which are relatable to unavoidable accidents and known risk treatments. The incorporation of this latter group of injuries provides the opportunity for compensating the medically-injured patient; removes the stigma from the possibly innocent health care provider; and encourages the introduction of innovative techniques, which, at higher risk, could result in more effective care.

To further the understanding of what is meant above by compensable medical injury and its implications, the following terms included within the definition are described. However for purposes of legislative drafting, each of these descriptions may be modified as to detail.

- *Physical harm* shall include pain, suffering, wounds, infections, disease or death. (*Note*: If the compensation system limits recovery to special damages only, then pain and suffering would be deleted.)
- *Bodily impairment* shall include temporary or permanent impairment or loss of bodily functions, bodily parts, mental or emotional processes, or behavioral controls. (*Note*: The bodily impairment description may be adjusted to exclude mental or emotional processes, or behavioral controls.)
- *Disfigurement* shall include scars or adverse changes in bodily appearance beyond those which are medically required.
- *Delay in recovery* shall include any undue additional time spent under care not substantially attributable to the condition for which medical intervention occurred and shall include consideration of the prior general health state of the patient.
- *Medical intervention* shall include the rendering, as well as the omission, of any care, treatment or services provided within the course of treatment administered by, or under the control of, a health care provider or within a health care institution.
- *Condition* shall include the general state of health of the patient prior to medical intervention.

Three abbreviated case histories are provided to illustrate the application of the definition of compensable injury within the non-fault-based context, and to indicate the likely outcomes of the compensation decision when these injuries are examined relative to the non-fault-based medical injury compensation system and the tort-liability system. It is important to stress that, although a judgment has been made as to whether or not the injuries are compensable, additional effort on making the definition somewhat more operational is required. Also, since individual states would be drafting non-fault-based legislation, the definition of compensable injury could vary from state to state.

In addition to the three medical case histories described below, there is a series of examples of medical injuries which probably would be compensable and a series of injuries which probably would not be compensable. As noted above, the determination of compensability is related to the definition of compensable (medical) injury and its interpretation. However, the validity of the application of the strict liability concept to the non-fault-based compensation system and the results derived do not hinge on the complete agreement with the judgments made concerning these examples. These illustrations are included primarily to assist the reader in understanding the definition of compensable injury.

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[7] 66 Cal. 2d 399, 426 P. 2d 525, 59 Cal. Rptr. 125 (1967).

Case 1 - Likely Compensable Injury Under Non-Fault-Based System

Mildred Smith, age 55 had elective cholecystectomy on January 10th. Her gall bladder contained several stones. No unusual features or problems were noted at surgery. For the next three days she did well but then increased drainage began to occur from the wound. A bacterial culture taken from the wound at that time grew staphylococcus aureus and with increasing signs of infection, a diagnosis of postoperative infection was made.

The infection did not respond well to antibiotics and Mrs. Smith's hospital stay was prolonged by several weeks. Her expenses were several times what she had anticipated and her convalescence at home was difficult and extended.

Careful review of the hospital records as well as examination of the pathological specimen and all laboratory samples revealed no break in surgical technique or improper procedure.

Mrs. Smith was compensated since her delay in recovery was associated with medical intervention and was not reasonably expected as a consequence of such intervention.

Under the tort-liability system it is likely that she would not be compensated.

Case 2 - Likely Non-Compensable Injury Under Non-Fault-Based System

Wilhelmina Jones, age 62, had complained of severe back pain for many years. At times the pain was so severe she couldn't work as a schoolteacher.

At the age of 61 she began to suffer the symptoms of severe depression. She went to see a psychiatrist who treated her with antidepressant medication. When after several months she showed no improvement, the psychiatrist recommended she enter the hospital for electroshock therapy (EST). She and her husband discussed this and then agreed.

Prior to the first treatment the psychiatrist obtained signed consent and explained the possible untoward consequences of EST. These consequences included cervical fracture.

After the completion of a series of ten EST, Mrs. Jones complained of worsened back pain so that she could no longer work. She went to an orthopedist who made a diagnosis of old compression fracture of a cervical vertebra, based upon X-ray finding. He could not establish that the pain was due to the fracture or that the pain she felt was any worse than what she had had prior to EST.

Mrs. Jones sued her psychiatrist for malpractice in connection with the fracture. In his defense he established that all EST was administered while she was anesthetized and her muscle actions were blocked by a relaxant. It was extremely unlikely that a fracture could have occurred under such conditions. Furthermore, a chest X-ray taken one year prior to hospital admission suggested (but did not clearly show) that the cervical fracture was present then.

The jury found for the plaintiff and awarded Mrs. Jones several thousand dollars.

Under the proposed system Mrs. Jones would not have been compensated. Her impairment was not more probably associated with medical intervention than with her pre-existing condition.

Case 3 - Likely Compensable Injury Under Both Tort-Liability and Non-Fault-Based Systems

Richard Revere, age 22, was seriously injured in an auto accident. He was rushed to a hospital where he was found to be in shock with signs of intra-abdominal bleeding. Blood was drawn from his arm for typing and cross-matching as part of the preparations for emergency surgery.

He was taken to the operating room where an exploratory laparotomy was performed. After removal of a considerable amount of blood a ruptured spleen was found and removed.

During the operation six units of whole blood were administered. Several hours after the operation, he was noted to have hematuria. Further examination revealed a bleeding tendency with ozing from the wound, and his blood plasma was pink. A diagnosis of transfusion reaction was made.

Despite efforts to prevent renal failure, his urine output declined and over the next few days he developed complete renal shutdown. He eventually died.

Examination of the clinical record showed that the blood sample with which the transfused blood had been cross-matched was type AB. Mr. Revere's military record showed he had type B blood. Apparently the sample tube had been mislabeled in the hospital emergency room where a woman with type AB blood had been admitted in labor at about the same time as Mr. Revere.

Mr. Revere's estate was compensated since the physical harm he suffered was associated with medical intervention and was not reasonably to be expected as a result of the intervention.

He likely would have been compensated as well under the tort-liability system.

COMPENSATION SYSTEM CHARACTERISTICS AND OBJECTIVES

The preceding discussion of the compensation system concept has alluded to several important system characteristics. Five major characteristics have been identified: equitability, efficiency, cost, effectiveness, and management. Each system characteristic can be operationally defined by several system objectives. The degree to which these system objectives are met by a given mode has been evaluated (see Section 6 of this Report). These system characteristics and objectives are introduced and discussed at this point because they provide guidance in the formulation of alternative modes, and their selection which will be discussed next.

(1) *Equitability*

Table 1 lists six system objectives associated with equitability: Accessibility to complainant; promptness of compensation; consistency of decisions and awards; fairness of system funding; assured payment of award; and compensation over the course of disability.

One of the foremost objectives of an equitable compensation system must be easy accessibility to complainants. It should not be necessary for the complainant to engage a lawyer in order to introduce a claim. Accessibility to complainants may be further enhanced if he is made aware of the medical injury compensation system when he enters the health care system or if the existence of an injury which may be compensable is pointed out to him upon impartial examination of his medical record.

Promptness of compensation will improve the equitability of the system particularly for low income complainants to whom a delay in receiving compensation causes financial hardship. The objective of promptness may, for instance, be achieved by making early partial compensation awards in cases in which the full extent of a disability will not be known for long periods.

Consistency of decision as to compensability and as to compensation awards has a profound effect on the equitability of the compensation system regardless of compensability and compensation limitations. It is firmly believed that all individuals experiencing the same medical injury and having the same losses should receive identical compensation. The compensation principle being employed is the recovery of the individual's total losses (specific damages).

Table 1

COMPENSATION SYSTEM CHARACTERISTICS AND OBJECTIVES

SYSTEM CHARACTERISTICS	SYSTEM OBJECTIVE
1. EQUITABILITY	1. ACCESSIBILITY TO COMPLAINANT 2. PROMPTNESS OF COMPENSATION 3. CONSISTENCY OF DECISIONS AND AWARDS 4. FAIRNESS OF SYSTEM FUNDING 5. ASSURED PAYMENT OF AWARD 6. COMPENSATION OVER COURSE OF DISABILITY
2. EFFICIENCY	7. INDUCEMENT TO SETTLEMENT 8. HIGH TOTAL PAYMENT/TOTAL SYSTEM INCOME 9. LOW COST/CASE
3. COST	10. PREDICTABILITY 11. LOW ADMINISTRATIVE COST 12. LOW TOTAL COST 13. AVOIDANCE OF DUPLICATE PAYMENT
4. EFFECTIVENESS	14. RECOVERY OF DIRECT LOSSES 15. RECOVERY OF TOTAL LOSSES
5. MANAGEMENT	16. PROVISION FOR ACCOUNTABILITY 17. POTENTIAL FOR ADMINISTRATIVE AND OPERATIONAL IMPROVEMENT 18. SAFEGUARD AGAINST EXAGGERATION AND FRAUD 19. PROVISION FOR MEDICAL INJURY DATA COLLECTION AND ANALYSIS

By fairness of funding is meant the allocation of system costs among the general public, the health care providers, governmental agencies, and the complainants, as perceived by the evaluator.

The ability of the health care provider or his insurer to make payment of awarded compensation is another objective that must be met to assure equitability.

Finally, equitability would suggest that compensation not be paid in a lump sum for long-term disabilities because the monetary value of the damage (injury) may change over the course of time; the life expectancy of the claimant can only be estimated actuarially; and the cost of subsequent care and rehabilitation may change appreciably.

(2) *Efficiency*

Three efficiency-associated objectives are listed: inducement to settlement; high total payment/total system income; and low cost/case.

As defined within this Study as well as others, the efficiency of a system is measured as the ratio of the monetary output (settlements and awards) to the input (the income or the cost of the compensation system). If settlements are made quickly, and without using the entire apparatus of the Commission, then the costs (the denominator in the above ratio) becomes small and the magnitude of the ratio (its efficiency) increases. High total payment to total system income is of course a statement of efficiency, as defined above. Costs per case include administrative, legal, medical expert, and other expenses which are incurred for the disposition of the claim (case).

(3) *Cost*

Predictability; low administrative cost; and low total cost encompass the list of system objectives whose attainments are a measure of system cost.

Predictability of system cost is an important objective of the compensation system because it allows for a more precise estimate of Commission and insurance company income requirements. Prediction of claim volume, claim category (e.g. by injury type, severity) and amounts awarded are needed components of such cost prediction.

Low administrative cost is, of course, an objective of any compensation system. On the other hand, low total cost, i.e., including the amounts awarded to claimants, must be viewed as an objective which is dependent on the social responsibility viewpoints of the system's creators.

One method for keeping system costs low without reducing the ability of the system to reimburse real expenses of claimants is the adoption of a rule whereby expenses paid by other compensation or insurance sources are not reimbursable (no-collateral-source rule) by the proposed non-fault-based medical injury system.

(4) *Effectiveness*

System objectives associated with effectiveness are recovery of direct losses, and recovery of total losses.

By effectiveness is meant the ratio of monetary recovery to monetary loss of the medically injured. The objectives listed in Table 1 make the distinction between recovery of direct losses (e.g. medical and hospital bills) and total losses (which include loss of future income). In both measures, effectiveness is improved as the magnitude of the ratio increases and approaches one.

(5) *Management*

This characteristic includes all aspects of control over the functioning of the compensation system, including provision for accountability; potential for administrative and operational improvement; safeguard against exaggeration and fraud; and provision for medical injury data collection and analysis.

By accountability is meant that all procedures and decisions would be subject to continuing review, and that the Medical Injury Compensation Commission staff would be responsible for execution of its mandate. This objective could be met by making the Commission a part of the State's Executive Department.

Potential for administrative and operational improvement is important in any large bureaucratic system. Such improvement may apply, for instance, to the number of local offices, the number and complexity of forms that must be filled out, and the need for legal assistance in dealing with the Commission. This objective appears to be particularly important for a non-fault-based medical injury compensation system because of the trend during the last decade for rapid expansion in the number of claims, and the amounts awarded under the fault-liability system.

The introduction of safeguards against exaggeration and fraud must be made an objective for any system that replaces trial by jury which is the traditional safeguard against such abuses. Such safeguards might be sought, for instance, through an inspection department working independently from the referres of the Commission.

The final management objective—provision for medical injury data collection and analysis—is included so as to enable the system to supply to various health-related organizations and agencies the information upon which they can base future decision regarding factors such as medical specialty accreditation, licensing procedure, continuing education, safety standards, and others.

FORMULATION OF ALTERNATIVE NON-FAULT-BASED MODES

Within the responsibilities and administration concept of the government-affiliated Medical Injury Compensation Commission, the problem being examined is one of enumerating, evaluating, and selecting the most appropriate mode of operation. The "mode" includes elements such as its method of fact finding, decision-making and appeal, as mentioned above. Further, it is necessary to decide:

(1) whether the system will be compulsory or optional;
(2) how claims will be initiated;
(3) whether there will be a screening procedure and how such a procedure will operate;
(4) whether compensable damages will be limited to special damages or whether they will also include general damages;
(5) what will be the rules for determining the amount of damages.

A "mode" then is a delineation of the specific form of the variable elements. In the left column of Table 2 are listed the seven most significant elements of the compensation system which are delineated as variables. The forms of their variations, as listed in the right-hand column, and the considerations for their selection are now discussed.

(1) The *selection of the compensation system* may be optional or compulsory. The option is between the tort-liability system and the non-fault-based system, and it may be open to the patient (complainant) and the health care provider. Retention of the tort-liability route would leave the complainant and health care provider with the maximum degree of legal choice. In particular, this option retains for the individual the satisfaction of judgment by his peers. The inadvisability of using a claim-magnitude criterion for the option has been pointed out. Inclusion of the option in a detailed analysis would entail the problem of predicting the volume and specifying the nature of claims going one way or the other. The effect of changing volume may be studied parametrically, but forecasting and assessing the nature (injury type, severity, etc.) of claims opting for tort-liability or non-fault-based would be difficult.

If the non-fault-based compensation mode is compulsory (i.e., if it is the sole remedy that the claimant is provided for pursuing his complaint), then a guarantee of financial responsibility by all health providers is necessary so as to assure satisfaction to the successful claimant. Such guarantee of financial responsibility may take the form of private insurance, self-insurance, or a state insurance fund, possibly in combination with re-insurance.

(2) *Claim initiation* at the patient's initiative (form 1) only corresponds to current practice under the tort-liability system. Consideration was given to a provision which would require all health care providers to report to the patient and to the Commission on medical injuries arising from the medical intervention in which they were involved. This provision has been discarded as not operable. The claim initiation mechanism of form 2 involves the patient originating a claim, and a procedure in which the patient is assisted by an impartial review in preparing his claim, although the claim must still be filed by him, his guardian or, if deceased, the executor of his estate. If it is properly publicized, the existence of the impartial review increases the probability that the medically-injured patient

Table 2

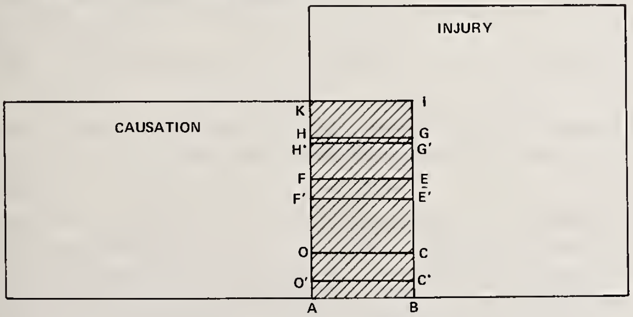
SELECTED COMPENSATION SYSTEM ELEMENTS AND THEIR FORMS

ELEMENT	NO.	FORM	NO.
SELECTION OF COMPENSATION SYSTEM	1	COMPULSORY OPTIONAL	1 2
CLAIM INITIATION	2	PATIENT-COMPLAINANT IMPARTIAL REVIEW AND PATIENT-COMPLAINANT	1 2
CLAIM SCREENING	3	NO SCREENING SCREENING PANEL ADMINISTRATOR	1 2 3
DETERMINATION OF COMPENSABILITY	4	REFEREE ARBITRATOR COURT OF LAW	1 2 3
LIMITATION OF COMPENSABILITY	5	SPECIAL DAMAGES SPECIAL AND GENERAL DAMAGES	1 2
DETERMINATION OF COMPENSATION	6	SCHEDULE SCHEDULE AND JUDGMENT	1 2
APPEAL	7	ADMINISTRATIVE BOARD COURT BOARD THEN COURT	1 2 3
		TOTAL NUMBER OF ALTERNATIVE MODES	432

be made aware of his injury and the available remedies. Such a review might be part of a comprehensive hospital grievance procedure addressing all patient complaints.

Under the form 2 claim initiation procedure, medical injury claims would be reviewed by the impartial reviewers possessing a sound background in health care and employed by the Medical Injury Compensation Commission. Although the inclusion of this form of review might increase the number of claims, it should result in providing needed assistance to the poorly-informed, unaware, and uneducated segments of the population. However, as noted, the decision to file a claim still resides with the injured party - the patient. Further, such review would be available only to hospital patients, though claim filing assistance could be rendered in all cases.

The effect on the volume of claims and awards of instituting an impartial review-assisted claim filing procedure is shown diagrammatically in Figure 3 (which is adapted from Mills' earlier representation). The figure depicts compensable medical injuries or potential claims (the cross-hatched region) as the union of the causation and injury sets; this representation is in keeping with the recommended strict liability concept. Different areas corresponding to the following claim initiation procedures are depicted: (1) by the patient only, as in the present tort-liability system, (2) assuming review of record only if the hospitalization duration exceeds a norm of if review is requested by the patient and (3) assuming that all medical records are reviewed upon discharge by the patient. For each of the three claim areas there is shown a smaller area representing compensation awards expected. Note should be taken that the largest of these areas, ABGH, does not include all potential claims, ABIK.



CLAIM INITIATION PROCEDURE	CLAIMS MADE	COMPENSATION AWARDS
BY PATIENT ONLY	A B C D	A B C' O'
HOSPITAL REVIEW AND PATIENT INITIATION: ASSUMPTION (a)*	A B E F	A B E' F'
HOSPITAL REVIEW AND PATIENT INITIATION: ASSUMPTION (b)**	A B G H	A B G' H'

*FOR EXAMPLE: ASSUMPTION (a) - A REVIEW OF ONLY THOSE RECORDS WHERE LENGTH OF STAY IN CARE EXCEEDS THE "EXPECTED LENGTH" AND WHERE THERE IS A REQUEST FOR REVIEW BY PATIENT

**ASSUMPTION (b) - REVIEW OF ALL MEDICAL RECORDS AT THE TIME OF PATIENT DISCHARGE

FIGURE 2

EFFECT OF CLAIM INITIATION PROCEDURE ON NUMBER OF COMPENSATION AWARDS

(3) *Claims screening*, is not necessarily used with any of the forms for determining compensability, element 4. The absence of screening is designated as form 1.

The purpose of claims screening (forms 2 and 3) is, through informal procedures, to advise the complainant and the other parties on the perceived merit of the complaint, and to facilitate early disposition of claims where no dispute arises. Claims screening need not involve the calling of witnesses or the hearing of testimony if the claim forms and medical records provide sufficient information. Medical opinion would be available, as needed, from staff members or consultants employed by the Medical Injury Compensation Board.

The suggested claims screening procedure is similar to the informal preliminary hearings conducted within the New York State Workmen's Compensation System. However, if after screening, the complaint was determined to be well-founded but no settlement resulted, the complainant would be provided assistance in securing expert medical testimony. The opinion of the screening panel would not be binding on either party although it can be expected that many claims would be resolved, (either discontinued or settled), based on the findings of such a panel.

Claims screening should reduce the number of claims proceeding on to the more formal, lengthy and elaborate determination of compensability. The potential output of the screening process is a finding of (i) compensability, (ii) probable compensability or (iii) no compensability. The finding is not binding on the claimant, i.e. he may pursue his claim regardless of the determination. If the finding is positive (i or ii) the system would include making available medical expertise to the claimant. This provision of assistance may reinforce the acceptance of the finding. It is expected that as a consequence of positive finding, a significant fraction of the claims would be settled by the insurance carrier. Since the proceeding is within a non-fault-based context, consent of the physician, which is usually required for settlement under tort-liability insurance contracts, is not viewed as a necessary condition for settling the claim.

If claims are screened, a panel (form 2), or a single administrator may be employed (form 3). Which of these two forms is more appropriate depends on the selection of the form for determination of compensability and has been discussed above.

(4) *Determination of Compensability* would be made by a referee under a system patterned after the Workmen's Compensation Systems (form 1). Additionally, arbitration appears compatible with non-fault-based proceedings, therefore, compensability may be determined by arbitrators (form 2). The minimum number of arbitrators would be three; one arbitrator being named by the claimant, another by the health care provider and these two arbitrators would select the third. Procedures such as those used by the American Arbitration Association would be used for compensability determination. The aforementioned requirement for a written record would suggest the need for professional arbitrators. Consideration of arbitrator selection would strongly depend on the projected number of

claims. As pointed out by Rick Carlson in the Senate hearings on the Kennedy Bill (S 3327),[8] a large number of arbitrations would make impractical the use of part-time, unpaid, or poorly paid arbitrators.

Determination of compensability by a court of law (form 3) appears less compatible with non-fault-based proceedings than arbitration. It is argued that the jury system is not particularly suitable if "guilt" or "negligence" are no longer issues related to the decision concerning compensability.

(5) *Compensability* may be limited to special damages, i.e., identifiable costs such as medical and hospital bills, loss of income, present worth of future loss of income and rehabilitation. The second form would add general damages, which includes non-monetary losses, such as pain and suffering, and loss of consortium.

(6) *Determination of compensation* would be arrived at by compensation schedules and judgment. The former (form 1) would be easier to administrate and would lead to fewer appeals. It is well recognized that the establishment of schedules for any conceivable medical injury, by type and severity, is the goal toward which the Medical Injury Commission should strive because it would remove the need for the exercise of discretionary judgment in each case. However, even the long-established New York State Workmen's Compensation Board provides for the exercise of some discretion in its award-making process (non-scheduled injuries). The second form, schedule and judgment, would be adopted unless provision is made to allow claims for general damages to use the tort-liability system. Carlson[9] has recommended that a fixed percentage of special damage awards, say 50%, be provided for pain and suffering every case. A more selective or a judgmental schedule may be necessary because "general damages" should include situations in which lack of informed consent is claimed: given the requirement that all medical injury claims which are compensable under the present tort system should be compensated under a no-fault system.

(7) The three *appeal* forms are not independently applicable to all the elements for determining compensability. For instance, it does not appear appropriate to have appeals from a court of law to an administrative board. The applicable combinations of these appeal forms are best treated within the alternative modes that are assembled from the elements and forms contained within Table 2.

SELECTION OF ALTERNATIVE NON-FAULT-BASED MODES

The maximum number of modes derived from the elements and their forms as listed on Table 2 is 432. Prior to applying a detailed quasi-quantitative evaluation, this number has been reduced by a judgmental elimination procedure. A significant number of the possible modes can be eliminated because they have obvious defects, such as the potential lack of constitutionality, or they are not sufficiently distinct to merit separate detailed evaluation. A selection procedure, employing these considerations, has been applied to four of the system elements: (1) selection of compensation system; (3) claims screening; (4) determination of compensability; and (7) appeal. The preceding discussion has indicated that the alternative forms of the remaining elements, (2) claim initiation, (5) limitation of compensability and (6) determination of compensation, are of sufficient importance to retain them for detailed evaluation.

Element (1): Selection of Compensation System. In the preceding discussion it was indicated that the effects on system volume and cost when an optional selection of the compensation system (form 2) is provided would be difficult to assess quantitatively. There are, in addition, strong qualitative reasons for excluding the option of a claimant seeking remedy under the tort-liability system. To the extent the tort-liability option is exercised, the non-fault-based system would not do the intended job of protecting health care providers from the inconvenience and stigma associated with court trial; the claimant from the personal cost of obtaining legal and medical assistence; and the public-at-large from the inconsistency of the fragmented, uncertain outcome resulting from the tort-liability system. If the civil liberties of all concerned are preserved by the recommended non-fault based system, then there appears to remain no reason why this remedy should not be the only one. Moreover, as noted earlier, the Workmen's Compensation System has set the example for such a compulsory administrative compensation system. Therefore, the optional form of element (1) is omitted in the reduced listing of alternate modes of Table 3.

Element (3): Claim Screening. The most importance difference to be decided among the three claim screening forms listed in Table 2 is whether their operation by a (single) administrator or by a panel would result in only a comparatively minor difference in cost which may be neglected for the present. A screening panel would include health care providers. A single screening administrator could, of course, consult with the Commission's medical experts without constituting a "panel". Therefore element (3) is reduced to two forms in Table 3; no claim screening (1) and a screening mechanism (2).

Element (4): Determination of Compensability. Similar arguments as that found in the above element (3) apply to the difference between the use of a single referee or arbitrators to determine compensability. It can be argued that the more precise the rules and guide lines of the Medical Injury Compensation Commission are, the more nearly will the decision of determining compensability be an administrative one, and thus, suitable for a single referee. In addition, the legal and medical representatives of both claimant and health care provider would be

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[8] U.S. Senate, Physicians Training, Facilities, and Health Maintenance Organizations - *Hearings,* Before the Subcommittee on Health, 92nd Congress, S935, S703, S837, S1182, S1301, S2827, S3327 Pt. 6, May 17, 18, 25 and 26, 1972.

[9] "The Feasibility of a No-Fault Compensation System for Medical Injuries." (Unpublished paper).

Table 3

SELECTED COMPENSATION SYSTEM ELEMENTS AND REDUCED NUMBER OF FORMS

ELEMENT	NO.	FORM	NO.
SELECTION OF COMPENSATION SYSTEM	1	COMPULSORY	1
CLAIM INITIATION	2	PATIENT-COMPLAINANT IMPARTIAL PARTY AND PATIENT-COMPLAINANT	1 2
CLAIM SCREENING	3	NO SCREENING SCREENING MECHANISM	1 2
DETERMINATION OF COMPENSABILITY	4	REFEREE	1
LIMITATION OF COMPENSABILITY	5	SPECIAL DAMAGES SPECIAL AND GENERAL DAMAGES	1 2
DETERMINATION OF COMPENSATION	6	SCHEDULE SCHEDULE AND JUDGMENT	1 2
APPEAL	7	BOARD THEN COURT	1
		TOTAL NUMBER OF ALTERNATIVE MODES	16

expected to play a role in the fact-finding and determination process.

The argument against the employment of a court of law to determine compensability has already been presented. Therefore, only modes including the referee for compensability determination have been included for evaluation.

Element (7): Appeal. The restriction on right of appeal to an administrative agency only may be considered to be a violation of due process and hence, could be declared unconstitutional. Appeal from an administrative (Commission) decision directly to a court would require review of both evidence and legality of procedures by the court and would thereby involve the court in a manner similar to the tort-liability proceeding, which the non-fault-based system is intended to avoid. In addition this dual review might become a heavy burden on the courts and would introduce delays in the final disposition of claims. The third appeal form of Table 1, "Board then Court", is therefore the recommended one. As established within many state Workmen's Compensation Systems, the right of appeal on findings (the decision and award) would be limited to the system, that is, appeal to the Board. However, where issues of procedure cannot be resolved within the system, the claimant would have the opportunity to appeal to the judicial system. The provisions for judicial review would be limited to examination of claimed errors of law or where the contention is entered that the findings of the Medical Injury Compensation Commission lacked substantial evidence. The decision rendered is then transmitted to the compensation system for possible reconsideration of the findings. The adoption of this appeal procedure appears suitable for the Medical Injury Compensation Commission and the non-fault-based medical injury compensation system.

The forms of the seven elements now remaining, as listed in Table 3, can be combined into 16 modes. For purposes of the following evaluation a further reduction to 12 modes can be made: by reasoning that determination of compensation by schedule *and* judgment (element 6, form 2) may not be needed if compensation is limited to special damages (element 5, form 1). Actually, one of these deleted modes is being re-introduced later and recommended for a transitory initial phase of the proposed Medical Injury Compensation Commission.

The 12 modes remaining for detailed evaluation are listed in Table 4. Here, for ease of designation in subsequent discussion, the numbering scheme of Table 1 is used to identify specific modes formed from the seven elements. For instance, Mode 1121111 designates a compul-

Table 4

ALTERNATIVE SYSTEMS FOR DETAILED EVALUATION*

MODE NUMBER	SELECTION OF COMPENSABILITY SYSTEM	CLAIM INITIATION	CLAIM SCREENING	DETERMINATION OF COMPENSABILITY	LIMITATION OF COMPENSABILITY	DETERMINATION OF COMPENSATION	APPEAL
1	1	1	1	1	1	1	1
2	1	1	1	1	2	1	1
3	1	1	1	1	2	2	1
4	1	1	2	1	1	1	1
5	1	1	2	1	2	1	1
6	1	1	2	1	2	2	1
7	1	2	1	1	1	1	1
8	1	2	1	1	2	1	1
9	1	2	1	1	2	2	1
10	1	2	2	1	1	1	1
11	1	2	2	1	2	1	1
12	1	2	2	1	2	2	1

*Numbers in table refer to the form designations found in Table 2.

sory system (1); in which claims are initiated by the patient only (1); claims are screened (2); compensability is determined by a referee (1); only special damages are compensable (1); compensation is based on schedules (1); and a two-stage appeals process consisting of the administrative board and court, (1) is used.

4. Evaluation of Non-Fault-Based Medical Injury Compensation Systems

Having narrowed down the list of rew candidate non-fault-based medical injury compensation system modes, the task remains to evaluate the remaining 12 candidate modes so that a single alternative can be recommended.

APPROACH

The selection is based on a quasi-quantitative scoring and weighting scheme employing simple ordinal scales. For each mode the extent of attainment of each of the 19 system objectives listed in Table 1 is scored. These objective-scores are summed for each of the five system characteristics listed within the table and multiplied by the weight given to the individual characteristics. The sum of the weighted scores is the mode score. Details of the scoring and weighting scheme are described later in this Section and in Appendix B.

Ordinal scales have been chosen for rating the attainment of system objectives because the diverse aspects of the compensation system, such as accessibility, promptness, fairness and accountability, do not lend themselves to more quantitative measures that might be based on time, cost or other measurable values. System objectives that are directly cost-related, such as total cost, administrative cost and recovery of loss, are also rated on an ordinal scale because dollar cost figures sufficient to permit quantitative comparison are not available.

The attainment of the 19 system objectives is rated (i) in comparison between the tort-liability, the non-fault-based, and a total social security insurance system and (ii) for each of the non-fault-based modes. The former scoring is *desirable* because it enables, in combination with weighting of the five system characteristics, an overall comparison among three major medical injury compensation concepts;

it is *necessary* in order to establish a basis of comparison for those system objectives for which all the non-fault-based modes have a single, common score (e.g. assured payment of award).

Attainment of system objectives was scored by the project staff based on their judgment as developed in the preceding discussions of the objectives, compensation system concepts, and non-fault-based modes.

The assignment of weights for the five system characteristics is based on the judgment of 10 evaluators from the project staff, the project consultants, and Calspan employees not connected with the project; the latter representing the viewpoint of the public. This somewhat broadened evaluation base was used in order to check whether any group would appear to introduce a strong bias in weighting and how such bias would influence the mode or system scores. As is discussed in more detail later in this Section and in Appendix B, the weighting bias does influence mode selection, but would not change the order or preference between the three major compensation systems.

The total number of evaluators that were asked to assign weights is, of course, much too small to be considered a representative sample of certain populations; the purpose being merely to find indications of the effect of evaluator bias on mode selection. The entire scoring and weighting method of evaluation could also have been performed by other methods. For instance, differences between mode scores would be more apparent if those scores that remain constant for all modes were omitted from the normalization and summation processes. However, in that case the resulting mode score would be biased toward those system characteristics having many variable objectives. An alternate method that might have yielded wider variation in results would be to assign a weight to each of the 19 system objectives. This method was not chosen because it was not felt that in the short time allotted to weight selection the 10 evaluators could exercise reasoned and balanced judgment in such a detailed weighting scheme. However, the method would lend itself to emphasizing opinions on simple objectives, e.g. that of low total cost, particularly if permitting a large range of weight. Even more difficult and time-consuming would be the assignment of scores (in addition to weights) by each evaluator.

COMPARISON OF THREE MAJOR MEDICAL INJURY COMPENSATION SYSTEMS

The reasons for performing a comparative evaluation of tort-liability, non-fault-based and total social security insurance compensation for medical injury have been pointed out in the preceding paragraphs. The evaluation is based on the degree of attainment of the compensation system objectives listed in Table 1. The possible scores for attainment of system objectives range from 1 (poor) to 5 (good). The results, which are summarized in Table 5 are now discussed.

Accessibility to complainants would be good in a total social security system since the bureaucratic apparatus of records and employees available for advising and supporting a potential claimant would be greatest. Accessibility within the present tort-liability system is judged poor, because the unsophisticated (poorly-educated, unacculturated or low-income) patient is often not aware of his rights and his potential claim, nor does he know how to initiate a claim. Moreover, many lawyers specializing in medical malpractice do not accept low-value cases because these cases do not yield adequate reimbursement of their expenses and sufficient income to offset the risks. The accessibility of the non-fault-based system to complainants falls between these two systems and is scored by a range (of 2-4) as its score would depend on a given mode's provisions for alerting the potential claimant and providing assistance.

Promptness of compensation is again poor in the tort-liability system since; because it is a "one-shot" system, it is general practice not to go to trial until the full extent of injury and disability can be proven. Promptness would be best in the total social security system because of its large bureaucratic apparatus. The achievement of promptness would be closely matched by the non-fault-based compensation system although it would depend somewhat on the adopted procedures. (We note that the score range of 3-4 for promptness under non-fault-based is narrower than its range of 2-4 for accessibility. A later portion of this section explains these differences in terms of the non-fault-based procedures under consideration.)

Consistency of decisions and awards are adjudged poor in the tort-liability system because, in general, neither the attorneys, nor the judges and jurors have continuity of experience with medical injury cases. The total social security system would score good because the personnel would be fully experienced and would make awards almost entirely by schedule. The non-fault-based system could score somewhat better than the tort system or just below the total social security system depending on the extent to which compensation schedules are established.

Fairness of system funding would be poor in the social security insurance system given that the entire cost of the medical injury compensation would be borne by the taxpayers without any special allocation of costs among those providing or specifically receiving health care services. The method of system funding recommended for all non-fault-based modes is discussed further on in this Section.[10] The tort system is difficult to judge with respect to system funding because funding under present tort procedures varies among geographical areas, among insurance companies, and among professions. The score of 3 for tort system fairness of funding is adopted primarily to signify that it falls between the extremes of the other two systems.

Payment of award would be completely assured in a total social security system provided that eligibility of the claim under the system compensability rules is satisfied. The non-fault-based system recommended would be established with sufficient guarantees of financial responsibility that default would be extremely rare. The present

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[10] All compensation system objectives which have a single score in Table 5 are discussed in Section 4.

Table 5

COMPARATIVE EVALUATION OF MEDICAL INJURY COMPENSATION SYSTEMS

CHARACTERISTIC	NO.	COMPENSATION SYSTEM OBJECTIVE	SCORE*		
			TORT-LIABILITY	NON-FAULT-BASED	TOTAL SOCIAL SECURITY
1. EQUITABILITY	1	ACCESSIBILITY TO COMPLAINANT	1	2-4	5
	2	PROMPTNESS OF COMPENSATION	1	3-4	5
	3	CONSISTENCY OF DECISIONS AND AWARDS	1	2-4	5
	4	FAIRNESS OF SYSTEM FUNDING	3	5	1
	5	ASSURED PAYMENT OF AWARD	3	4	5
	6	COMPENSATION OVER COURSE OF DISABILITY	1	4	5
2. EFFICIENCY	7	INDUCEMENT TO SETTLEMENT	3	4-5	1
	8	HIGH TOTAL PAYMENT/TOTAL SYSTEM INCOME	1	4	5
	9	LOW COST/CASE	1	3	5
3. COST	10	PREDICTABILITY	1	4-5	5
	11	LOW ADMINISTRATIVE COST	2	3-4	5
	12	LOW TOTAL COST	5	2-4	1
	13	AVOIDANCE OF DUPLICATE PAYMENT	1	5	5
4. EFFECTIVENESS	14	RECOVERY OF DIRECT LOSSES	5 IF HIGH 1 IF LOW	3-4	3-4
	15	RECOVERY OF TOTAL LOSSES		3-4	3-4
5. MANAGEMENT	16	PROVISION FOR ACCOUNTABILITY	1	5	3
	17	POTENTIAL FOR ADMINISTRATIVE AND OPERATIONAL IMPROVEMENT	1	5	3
	18	SAFEGUARD AGAINST EXAGGERATION AND FRAUD	5	2-4	1
	19	PROVISION OF MEDICAL INJURY DATA COLLECTION AND ANALYSIS	1	4	3

*SCORE OF 1 DESIGNATES POOR
SCORE OF 5 DESIGNATES GOOD

tort system is rated with fair (score 3) because although default on payment of awards appears not to be a significant problem, actual safeguards (such as compulsory insurance) do not exist.

Compensation over the course of a disability is least well assured as to adequacy and extent in the tort-liability system where the above-mentioned "one-shot" nature of the award determination prevents full recognition of the potential for changes in the severity of the disability and where it is difficult to anticipate the financial needs of a claimant for treatment, rehabilitation and care far in advance. Total social security would appear to be best set-up for periodic review of cases and adjustment of compensation rates. The recommendations for the non-fault-based system would attempt to come close to the potential of the total social security system in achieving this objective.

Inducement to settlement would be poor in the social security system because the health care provider has no direct financial stake in the award. It would be good, or nearly good in the non-fault-based system because there will be insurance coverage, and it is adjudged fair in the tort system where the prospect for settlement depends strongly on the skills of the attorneys and the willingness of the practitioner, as well as on the merits of the claim.

The total payment to system income ratio under the tort-liability system is low (or poor). The absence of the need to involve attorneys in most cases would make the social security system good in this respect. The non-fault-based system would have regulated attorneys' fees (as in the Workmen's Compensation System) and would rate nearly as high as the social security system. Tort-liability and social security systems would rate similarly as to cost per case. Here the no-fault system would rate a little lower (score 3), on account of the cost of supporting a separate Medical Injury Compensation Commission.

Predictability of costs is poor under the tort-liability system because of the lack of continuity cited earlier and it would be good under a total social security system. In a non-fault-based system, predictability would be nearly good or good, depending on the specific compensability limitations and award setting rules being implemented.

Administrative costs are judged quite high (score 2) in the tort-liability system even though they do not appear as a readily identifiable system cost in the record. They are believed to be high because of the fragmented nature of the system and the need, on the part of insurance companies, to anticipate claims over long periods. The total social security system could be expected to have the lowest administrative cost, because to some extent medical injury compensation would parallel other administrative procedures in the health care area. Administrative costs in a non-fault-based system would lie between tort-liability and social security; the score depending on the detailed provisions for a particular mode.

Total cost (including awards) would be expected to be high (poor) under total social security, because the volume of eligible claims brought forth would be high, and it is, by comparison, low (good) under the tort system. Total cost of the non-fault-based system would depend on its rules and procedures, as explained later.

In the tort-liability system, the existence of collateral sources of compensation is not divulged; therefore, a claimant may recover damages or expenses from more than one source and thus the system cost tends to be increased (poor). Both a total social security and the recommended non-fault-based system would incorporate a no-collateral-source rule under which award payment would be made only in the absence of collateral payment, thereby resulting in lower system cost (good).

The tort system encompasses both extreme scores for recovery of losses. The tendency is for very good recovery ratios in case of high claimed losses, perhaps because such cases tend to be more impressive to attorneys and juries; conversely, small losses tend to be unrecompensed because as noted earlier, attorneys are not inclined to accept such cases. Both total social security and non-fault-based systems would be expected to avoid either extreme (score range from 3-4).

The tort-liability system has no separate accountability of its functioning as to medical injury compensation, apart from the general appeals and administrative judicial review procedures. The recommended non-fault-based system would have provisions for accountability within the Medical Injury Compensation Commission and from the Commission to the state legislature. The total social security system would fall between these extremes; its accountability for practical purposes being lower than that of the non-fault-based system because it may not have a separate administrative apparatus. For the same reasons, the comparative scoring of the three systems for potential administrative and operational improvement would also follow this pattern.

As mentioned earlier, the jury system is traditionally regarded as being the safeguard against the exercise of exaggeration and fraud in presenting any civil claim; hence, the tort system ranks high (good) for low susceptibility to exaggeration and fraud. It seems likely that the social security system would fare poorly in this respect. The non-fault-based system should fall between those extremes depending on its detailed procedures. A single score is used because details for such safeguards have not been devised for the proposed non-fault-based compensation modes.

The objective of collecting, analyzing and making available to other agencies data on medical injuries, claims, settlements and awards is barely met under the tort-liability system, notwithstanding the records of individual insurance companies and their communications, in some instances to medical societies (e.g. New York State Medical Society). The non-fault-based system would incorporate recording and analyzing of data from the outset. The score of 4 (rather than 5) is given to indicate that recording rules would be established to protect the confidentiality of the individual record at the expense of completeness. The total social security system would be expected to be a somewhat poorer record-keeper because injury compensation would constitute only a small part of its total record load and the record might therefore be less accessible or complete.

SYSTEM OBJECTIVE SCORES COMMON TO ALL NON-FAULT-BASED MODES

It should be noted from Table 5 that 9 of the 19 system objectives associated with the non-fault-based medical injury compensation system have single-value scores, denoting that the extent of attainment of those objectives is common to the 12 modes under evaluation. A different administrative organization for the non-fault-based compensation system, e.g. one not incorporating a state-affiliated Medical Injury Compensation Commission, might have a different set of common objective scores. The common objective scores of the system recommended here are further elaborated on in this Section.

The first common objective score listed in Table 5, fairness of system funding, is crucial and has the highest score among those within the equitability objective. Here we must first note that equitability is subjectively determined and its attainment must be scored "as perceived by the public". System funding, i.e. the allocation of system costs among health care providers, the consumers and the taxpayers, should probably be judged in conjunction with information on cost. It is difficult to make a valid judgment on the public perception of cost allocation ratios without regard for the amounts. The public response to the fairness of saddling the taxpayer with the administrative cost of the Medical Injury Compensation Commission is difficult to determine since it depends, in part, on the total magnitude of the individual state's budget. This question must be further examined after the anticipated dollar costs for the entire system are obtained. It is believed that the differences in costs attributable to selection of any of the 12 modes under consideration would not influence significantly the cost allocation decision. Therefore, fairness of system funding is considered to result in a common (invariable) objective score here.

Payment of award under a non-fault-based system can be assured by a number of mechanisms: insurance of health care providers may be made compulsory; alternatively, they may be required to post bond. In addition, a state insurance fund may be created, or re-insurance may be state-supported. No recommendation is made, at this point, among the alternative approaches and therefore, a single score is used.

Compensation over the course of the disability is postulated for the non-fault-based system, largely in contrast to the one-time award customarily made by the courts and by some workmen's compensation systems. While the method recommended here has not been specified in detail, it is anticipated that the merits of long-term disabilities and injuries be periodically reviewed, not necessarily with a hearing, in order to assess the need for continuation of payment and to reassess the amount of payment in light of economic conditions. The latter may take the form of periodic legislative review of compensation rates or of pegging compensation rates to a cost-of-living index.

Two of the three efficiency-related system objectives received single-value scores: high total payment/total system income and low cost/case. It is recognized that mode variations, such as the absence or use of screening, with its attendant inducement to settlement of meritorious cases and abandonment of low-prospect claims, would affect both these efficiency ratings somewhat; however, the present analysis is not sensitive enough to assess these differences.

The remaining single-value scores—avoidance of duplicate payment; provision for accountability; potential for administrative and operational improvement; and provision for medical injury data collection and analysis have been discussed in earlier portions of this section.

EFFECT OF NON-FAULT-BASED SYSTEM ELEMENTS ON ATTAINMENT OF SYSTEM OBJECTIVES

The variable score given to system objectives for non-fault-based compensation modes in Table 5, and discussed earlier, is based on the recognition of the anticipated effect of the selected system mode. In Table 6 the non-fault-based system objectives and their scores are once again listed and the elements affecting the attainment of the objective are shown on the right. (The elements are shown by number according to their listing in Table 2.) How the forms of these elements are expected to affect the scores is now discussed.

Accessibility of the system to the potential claimant is affected by the claim initiation procedure and by the claim screening procedure. The former improves accessibility if form 2 is chosen, i.e., claim initiation directly by the patient, or by an impartial party and then the patient. Accessibility may further be improved if the claim screening mechanism includes providing medical expertise to a claimant whose case appears to be meritorious. It should be realized that the score range of 2-4, which was established for accessibility earlier in comparison with the tort-liability and total social security systems would take on specific values depending on which of the two elements and forms or which combination of them constitutes the mode under consideration. The four possibilities are shown below:

Claim Initiation		Screening Mechanism	No Screening	Score
Impartial Party	Claimant Only			
X		X		4.0
X			X	3.3
	X	X		2.6
	X		X	2.0

The above illustrates how these two elements and associated forms affect the scoring in principle. In the scoring procedure used (shown in Table 7) the raw score range is

Table 6

EFFECT OF NON-FAULT-BASED SYSTEM ELEMENTS ON SYSTEM CHARACTERISTICS

SYSTEM CHARACTERISTIC	NO.	COMPENSATION SYSTEM OBJECTIVE	SCORE (1 - 5)	AFFECTING ELEMENTS, NO.
1. EQUITABILITY	1	ACCESSIBILITY TO COMPLAINANT	2-4	2, 3 *
	2	PROMPTNESS OF COMPENSATION	3-4	3
	3	CONSISTENCY OF DECISIONS & AWARDS	2-4	6
	4	FAIRNESS OF SYSTEM FUNDING	5	—
	5	ASSURED PAYMENT OF AWARD	4	—
	6	COMPENSATION OVER COURSE OF DISABILITY	4	—
2. EFFICIENCY	7	INDUCEMENT TO SETTLEMENT	4-5	2, 3
	8	HIGH TOTAL PAYMENT/TOTAL SYSTEM INCOME	4	—
	9	LOW COST/CASE	3	—
3. COST	10	PREDICTABILITY	4-5	5, 6
	11	LOW ADMINISTRATIVE COST	3-4	3, 5, 6
	12	LOW TOTAL COST	2-4	2, 3, 5, 6
	13	AVOIDANCE OF DUPLICATE PAYMENT	5	—
4. EFFECTIVENESS	14	RECOVERY OF DIRECT LOSSES	3-4	5, 6
	15	RECOVERY OF TOTAL LOSSES	3-4	5, 6
5. MANAGEMENT	16	PROVISION FOR ACCOUNTABILITY	5	—
	17	POTENTIAL FOR ADMINISTRATIVE & OPERATIONAL IMPROVEMENT	5	—
	18	SAFEGUARD AGAINST EXAGGERATION & FRAUD	2-4	3, 5, 6
	19	PROVISION OF MEDICAL INJURY DATA COLLECTION AND ANALYSIS	4	—

*SEE TABLE 2 FOR IDENTIFICATION OF ELEMENT NO.'s expanded from 2-4 to 1-5 so that each raw score is an integer.

Promptness of compensation is affected by claim screening because screening should induce settlement and thereby tends to reduce the case load of the referee.

Consistency of decisions and awards would be affected by the form taken for determination of compensation. If form 2 (schedule plus judgment) is selected, consistency will be reduced necessarily.

Settlement should be affected by the same elements that affect accessibility to the claimant. It is believed that claims screening would particularly induce settlement of uncontested and low monetary-value cases.

Predictability will be reduced if compensability is extended to general damages and if the amount awarded is based on schedule plus judgment.

Administrative cost is increased if a screening mechanism is introduced (regardless of other effects of screening, such as more settlements). In addition, compensability of general damages and heavy reliance on judgment in determining compensation will somewhat increase the administrative load, e.g. by leading to more frequent appeals.

Total cost is affected by the largest number of elements; aid in claim initiation by impartial parties will increase the number of claims made, hence the system cost; claim screening is believed to lower system cost by early elimination of non-meritorious and settlement of definitely meritorious cases; further, provision for general damages would increase total cost, as will, probably, allowance for judgment in setting awards.

The completeness of recovery of losses is affected by limitations on compensability as well as the exercise of judgment in setting the award. Note that recovery of direct and total losses are rated separately because they are independently affected by these elements.

The only one of the four management objectives considered dependent on mode selection is safeguards against exaggeration and fraud. It is believed that abuse would be reduced by the employment of screening; by limitation of compensability to special damages and by elimination of the exercise of discretion in setting the award.

MODE EVALUATION

Having reduced the number of candidate alternative modes for a non-fault-based medical injury compensation system and having established which elements of those modes have the same effect on attaining system objectives and which elements have effects depending on the form taken in their mode, there remains the task of evaluation and selection of the most appropriate mode.

The scoring and weighting scheme has been briefly introduced at the beginning of this Section. It is now discussed in detail. Each candidate mode is scored based on its adjudged degree of attainment of the 19 objectives listed in Table 1. A raw-score range of 1 (poor) to 5 (good) is utilized. The problem of combining the scores is handled in the following way: The raw scores, S_r, are converted into comparative scores, CS, in order to relate them to the range of scores of the three major compensation systems in Table 5. For example, "Accessibility to Claimant", has a comparative score range of 2 to 4 (see Table 5) which is related to its raw score range of 1 to 5 as follows:

Raw Score, S_r	Comparative Score, CS
1	2.0
2	2.5
3	3.0
4	3.5
5	4.0

A total comparative score T for each system characteristic can now be obtained by summing the comparative scores

$$T = \Sigma\, CS$$

To illustrate the method, the raw scores S_r, the comparative score range, CS_r, comparative scores CS, and the total comparative score T are listed below for "Equitability" in one mode:

Equitability Objective Scores	S_r	CS_r	CS
Accessibility to Claimant	1	2-4	2
Promptness of Compensation	1	3-4	3
Consistency of Decisions and Awards	5	2-4	4
Fairness of System Funding	5	0	5
Assured Payment of Award	4	0	4
Compensation Over Course of Disability	4	0	4
Total Comparative Score, T_i			22

The total comparative score is then normalized by dividing T_i by the maximum attainable comparative score, M_i, for each system characteristic (i). In the above example, the maximum attainable comparative score is 25, and the normalized comparative score for the system characteristic (Equitability) is

$$N_i = \frac{T_i}{M_i} = 0.88$$

Next, the normalized comparative score, N_i, is multiplied by the weight, W_i, derived for the system characteristic and the weighted normalized scores for the five system characteristics are combined to obtain the Mode Score, $\Sigma\, W_i N_i$.

The weighting scale employed ranges from 1 (unimportant) to 9 (very important). The method employed for arriving at weights, W_i, with the aid of 10 evaluators, is discussed in Appendix B. The correlation of the evaluators' judgments and the rationale for the selection of weights for mode score computation is also discussed there. These selected weights are tabulated below:

Weight Selection	Weight				
	W_1	W_2	W_3	W_4	W_5
Maximum Correlation, (Σr) max.	9	4	3	7	5
Minimum Correlation, (Σr) min.	8	4	4	4	8
Minimum Cost Weight, (W_3) min.	9	5	1	7	6
Maximum Cost Weight, (W_3) max.	8	5	9	7	5
Equal Weight, (Unweighted)	1	1	1	1	1

The results of the mode score calculations are listed in Tables 7 a, b, c, d and e. In each table, the high and the low mode scores are circled and the normalized range, R_n, of the mode scores is shown. For each table:

$$R_n = \frac{(\Sigma WN)\ \text{max} - (\Sigma WN)\ \text{min}}{(\Sigma WN)\ \text{max}}$$

Inspection of the four mode evaluation Tables 7 reveals only a narrow range of variation (about 10%) between mode scores. This result is not surprising if it is realized (i) that the evaluation is only made among non-fault-based compensation modes; (ii) that almost one half of the objective scores are identical for each mode (as discussed in Section 6.3 above); and (iii) that there are offsetting trends among weight-score products.

The mode scores for non-fault-based medical injury compensation systems are summarized in Table 7. Here, the computed scores are not listed, because they are not comparable in that they are based on nonnormalized weights. From Table 8 and Table 7 it can be seen that Mode No. 3, Index No. 1111221, has consistently the lowest or near-lowest mode score. Modes 10, 11 and 12, Index No. 1221111, 1221211 and 1221221 have the high mode scores within a narrow range. These three modes all have in common claim initiation with the aid of a third party and a claim screening mechanism. They differ in awarding general damages and the use of judgment in setting compensation amounts.

To test the sensitivity of the weighting and scoring scheme and to demonstrate that it differentiates between more contrasting compensation systems, mode scores were calculated for the tort-liability system and three of the non-fault-based modes (Table 9). In the computation of the tort-liability system, scores listed in Table 5 are used and the non-fault-based objective scores are taken from Table 7, with the exception of the first mode in Table 9 which had not previously been scored. To establish comparability between the mode scores in Table 9, the objective scores for each system property are normalized on the basis of a maximum score 5 for each objective. Tort-liability system mode scores are computed for a low and for the highest possible score for effectiveness. The latter, an unreasonably high score, is used only to test its effect on the mode score Σ WN.

Inspection of Table 9 also shows the effect of grouping several objective-scores in one system characteristic. For instance, the four cost objectives used, while all good and valid, tend to mask the low total cost performance when a single weight is used for all cost objectives. This masking effect is particularly apparent in comparing the tort system with the non-fault-based system in the Table. Here, the total cost is rated poor whereas the three compared non-fault-based modes are rated good with a score ratio of 5 to 1; yet the total cost characteristic score W_3N_3 has a ratio of less than 1 to 1! On the other hand, whether or not the low total cost objective should be allowed to control, depends on the range of total cost for the modes considered—which has not been estimated.

The mode scores in Table 9 indicate that the weighting and scoring system differentiates drastically between the two compensation systems. The small comparative difference among the non-fault-based systems that differ only in some detail is again clearly shown.

MODE SELECTION

In view of the small difference in mode score computed for modes 10, 11 and 12 (Table 7), it is appropriate to review the underlying real differences between these modes before making a final recommendation.

The three modes differ only in elements (5) and (6), limitation of compensability and determination of compensation.

Two interrelated considerations were examined relative to the question of compensation; these are (1) what limitations, if any, should be placed on the factors affecting compensation and (2) how should the amount of compensation be determined. With respect to the first consideration and in view of the body responsible for making compensation decisions, it appears now that compensation should be limited to special damages only. That is, where the referee has decided in favor of the complainant, the award would be based on the complainant's medical and hospital expenses, past and anticipated loss of income, expenses entailed (medical, legal, other) in pursuing the claim, and required expenses for recovery, rehabilitation and occupational therapy services. At this time, it does not appear administratively feasible and economically sound to include those non-monetary losses which are categorized as general damages—including pain and suffering, loss of consortium, etc.

The actual determination of amount of compensation would best be accomplished by utilizing compensation schedules in connection with whatever judgment is required. Initially, it can be expected that there will be a limited number of appropriate schedules to handle the broad range of medical injury claims. However, with the passage of time and the gathering of experience, the Medical Injury Compensation Commission and Board would develop a more complete set of schedules and thus award determination would be based on judgment to a lesser degree.

Special note should be made of the fact that although basic schedules would be relied upon for award determina-

Table 7a

ALTERNATIVE NON-FAULT-BASED SYSTEM MODE EVALUATION

$(\Sigma r)_{max}$

MODE NUMBER	MODE DESIGNATION							EQUITABILITY $W_1 = 9$ $M_1 = 25$									EFFICIENCY $W_2 = 4$ $M_2 = 12$						COST $W_3 = 3$ $M_3 = 18$							EFFECTIVENESS $W_4 = 7$ $M_4 = 8$					MANAGEMENT $W_5 = 5$ $M_5 = 18$							MODE SCORE (Σ WN)
	1	2	3	4	5	6	7	1	2	3	4	5	6	T_1	N_1	W_1N_1	7	8	9	T_2	N_2	W_2N_2	10	11	12	13	T_3	N_3	W_3N_3	14	15	T_4	N_4	W_4N_4	16	17	18	19	T_5	N_5	W_5N_5	
1	1	1	1	1	1	1	1	1	1	5							1						5	4	4					3	1						4					
								2	3	4	5	4	4	22	.88	7.92	4	4	3	11	.92	3.68	5	3.75	3.5	5	17.25	96	2.88	3.5	3	6.5	.81	5.67	5	5	3.5	4	17.5	.97	4.85	25.0
2	1	1	1	1	2	1	1	1	1	5							1						3	2	3					3	3						2					
								2	3	4	5	4	4	22	.88	7.92	4	4	3	11	.92	3.68	4.5	3.25	3	5	15.75	.87	2.61	3.5	3 5	7	.87	6.09	5	5	2.5	4	16.5	.92	4.60	24.9
3	1	1	1	1	2	2	1	1	1	1							1						1	1	2					5	5						1					
								2	3	2	5	4	4	20	.80	7.20	4	4	3	11	.92	3.68	4	3	2.5	5	14.5	.81	2.43	4	4	8	1	7.00	5	5	2	4	16	.89	4 45	24.8
4	1	1	2	1	1	1	1	3	5	5							4						5	5	5					3	1						5					
								3	4	4	5	4	4	24	.96	8.64	4.75	4	3	11.75	.98	3.92	5	4	4	5	18	1	3.00	3.5	3	6.5	.81	5.67	5	5	4	4	18	1	5.00	26.2
5	1	1	2	1	2	1	1	3	5	5							4						3	4	4					3	3						4					
								3	4	4	5	4	4	24	.96	8.64	4.75	4	3	11.75	.98	3.92	4.5	3.75	3.5	5	16.5	.92	2.76	3.5	3.5	7	.87	6.09	5	5	3.5	4	17.5	.97	4.85	26.3
6	1	1	2	1	2	2	1	3	5	1							4						1	3	3					5	5						3					
								3	4	2	5	4	4	22	.88	7.92	4.75	4	3	11.75	.98	3.92	4	3.5	3	5	15.5	.86	2.58	4	4	8	1	7.00	5	5	3	4	16.5	.92	4.60	26.0
7	1	2	1	1	1	1	1	4	1	5							2						5	3	3					3	1						4					
								3.5	3	4	5	4	4	23.5	.94	8.46	4.25	4	3	11.25	.94	3.76	5	3.5	3	5	16.5	.92	2.76	3.5	3	6.5	.81	5.67	5	5	3.5	4	17.5	.97	4.85	25.5
8	1	2	1	1	2	1	1	4	1	5							2						3	2	2					3	3						2					
								3.5	3	4	5	4	4	23.5	.94	8.46	4.25	4	3	11.25	.94	3.76	4.5	3.25	2.5	5	15.25	.85	2.55	3.5	3.5	7	.87	6.09	5	5	2.5	4	16.5	.92	4.60	25.5
9	1	2	1	1	2	2	1	4	1	1							2						1	1	1					5	5						1					
								3.5	3	2	5	5	4	21.5	86	7.74	4.25	4	3	11.25	.94	3.76	4	3	2	5	14	.78	2.32	4	4	8	1	7.00	5	5	2	4	16	.89	4.60	25.3
10	1	2	2	1	1	1	1	5	5	5							5						5	5	4					3	1						5					
								4	4	4	5	4	4	25	1	9.00	5	4	3	12	1	4.00	5	4	3.5	5	17.5	.97	2.91	3.5	3	6.5	.81	5.67	5	5	4	4	18	1	5.00	26.6
11	1	2	2	1	2	1	1	3	3	3							5						3	4	3					3	3						4					
								4	4	4	5	4	4	25	1	9.00	5	4	3	12	1	4.00	4.5	3.75	3	5	16.25	.90	2.70	3.5	3.5	7	.87	6.09	5	5	3.5	4	17.5	.97	4.85	26.6
12	1	2	2	1	2	2	1	5	5	1							5						1	3	2					5	5						3					
								4	4	2	5	4	4	23	.92	8.28	5	4	3	12	1	4.00	4	3.5	2.5	5	15	.83	2.50	4	4	8	1	7.00	5	5	3	4	17	.94	4 70	26.5

$R_N = .10$

NOTES

1. FOR EACH SYSTEM NUMBER. THE TOP AND LOWER ROW ENTRIES ARE RAW SCORES AND COMPARATIVE SCORES, RESPECTIVELY. RAW SCORES ARE FROM 1 (POOR) TO 5 (GOOD). COMPARATIVE SCORES ARE SCALED TO THE SCORES OF TABLE 4.

2 W_i = WEIGHT ASSOCIATED WITH SYSTEM CHARACTERISTIC; RANGES FROM 1 THROUGH 9

3. M_i = MAXIMUM POSSIBLE COMPARATIVE SCORE FOR NON FAULT-BASED SYSTEMS (TABLE 4)

4. T_i = TOTAL COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC

5. N_i = NORMALIZED COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC = $\frac{T_i}{M_i}$

6 W_iN_i = WEIGHTED SCORE FOR A SYSTEM CHARACTERISTIC

7. Σ WN - MODE SCORE

8. R_N = NORMALIZED MODE SCORE RANGE

9. r = CORRELATION COEFFICIENT

Table 7b
MODE EVALUATION
$(\Sigma r)_{min}$

MODE NUMBER	MODE DESIGNATION							EQUITABILITY $W_1 = 8$ $M_1 = 25$									EFFICIENCY $W_2 = 4$ $M_2 = 12$						COST $W_3 = 4$ $M_3 = 18$							EFFECTIVENESS $W_4 = 4$ $M_4 = 8$					MANAGEMENT $W_5 = 8$ $M_5 = 18$							MODE SCORE (ΣWN)
	1	2	3	4	5	6	7	1	2	3	4	5	6	T_1	N_1	W_1N_1	7	8	9	T_2	N_2	W_2N_2	10	11	12	13	T_3	N_3	W_3N_3	14	15	T_4	N_4	W_4N_4	16	17	18	19	T_5	N_5	W_5N_5	
1	1	1	1	1	1	1	1	1	1	5							1						5	4	4					3	1						4					
								2	3	4	5	4	4	22	.88	7.04	4	4	3	11	.92	3.68	5	3.75	3.5	5	17 25	.96	3.86	3.5	3	6.5	.81	3.24	5	5	3.5	4	17.5	.97	7.76	25.6
2	1	1	1	1	2	1	1	1	1	5							1						3	2	3					3	3						2					
								2	3	4	5	4	4	22	88	7.04	4	4	3	11	.92	3.68	4.5	3.25	3	5	15.75	.87	3.48	3.5	3.5	7	.87	3.48	5	5	2.5	4	16.5	.92	7.36	25.0
3	1	1	1	1	2	2	1	1	1	1							1						1	1	2					5	5						1					
								2	3	2	5	4	4	20	.80	6.40	4	4	3	11	.92	3.68	4	3	2.5	5	14.5	.81	3.29	4	4	8	1	4.00	5	5	2	4	16	.89	7.12	24.4
4	1	1	2	1	1	1	1	3	5	5							4						5	5	5					3	1						5					
								3	4	4	5	4	4	24	.96	7.68	4.75	4	3	11 75	.98	3.92	5	4	4	5	18	1	4.00	3.5	3	6.5	.81	3.24	5	5	4	4	18	1	8.00	26.8
5	1	1	2	1	2	1	1	3	5	5							4						3	4	4					3	3						4					
								3	4	4	5	4	4	24	.96	7.68	4.75	4	3	11 75	.98	3.92	4.5	3.75	3.5	5	16.5	.92	3.78	3.5	3.5	7	.87	3.48	5	5	3.5	4	17.5	.97	7.76	26.5
6	1	1	2	1	2	2	1	3	5	1							4						1	3	3					5	5						3					
								3	4	2	5	4	4	22	.88	7.04	4.75	4	3	11.75	.98	3.92	4	3.5	3	5	15.5	.86	3.44	4	4	8	1	4.00	5	5	3	4	16.5	.92	7.36	25.8
7	1	2	1	1	1	1	1	4	1	5							2						5	3	3					3	1						4					
								3.5	3	4	5	4	4	23.5	.94	7.52	4.25	4	3	11.25	.94	3.76	5	3.5	3	5	16.5	.92	3.78	3.5	3	6.5	.81	3.24	5	5	3.5	4	17.5	.97	7.76	26.0
8	1	2	1	1	2	1	1	4	1	5							2						3	2	2					3	3						2					
								3.5	3	4	5	4	4	23.5	.94	7.52	4.25	4	3	11.25	.94	3.76	4.5	3.25	2.5	5	15.25	.85	3.40	3.5	3.5	7	.87	3.48	5	5	2.5	4	16.5	.92	7.36	25.8
9	1	2	1	1	2	2	1	4	1	1							2						1	1	1					5	5						1					
								3.5	3	2	5	5	4	21.5	86	6.88	4.25	4	3	11.25	.94	3.76	4	3	2	5	14	.78	3.12	4	4	8	1	4.00	5	5	2	4	16	.89	7.12	24.8
10	1	2	2	1	1	1	1	5	5	5							5						5	5	4					3	1						5					
								4	4	4	5	4	4	25	1	8.00	5	4	3	12	1	4 00	5	4	3.5	5	17.5	.97	3.88	3.5	3	6.5	.81	3.24	5	5	4	4	18	1	8.00	27.1
11	1	2	2	1	2	1	1	3	3	3							5						3	4	3					3	3						4					
								4	4	4	5	4	4	25	1	8.00	5	4	3	12	1	4.00	4.5	3 75	3	5	16.25	.90	3.60	3.5	3.5	7	.87	3.48	5	5	3.5	4	17.5	.97	7.76	26.8
12	1	2	2	1	2	2	1	5	5	1							5						1	3	2					5	5						3					
								4	4	2	5	4	4	23	.92	7.36	5	4	3	12	1	4 00	4	3.5	2.5	5	15	.83	3.12	4	4	8	1	4.00	5	5	3	4	17	.94	7.52	25.9

$R_N = .10$

NOTES

1 FOR EACH SYSTEM NUMBER. THE TOP AND LOWER ROW ENTRIES ARE RAW SCORES AND COMPARATIVE SCORES, RESPECTIVELY. RAW SCORES ARE FROM 1 (POOR) TO 5 (GOOD) COMPARATIVE SCORES ARE SCALED TO THE SCORES OF TABLE 4

2 W_i = WEIGHT ASSOCIATED WITH SYSTEM CHARACTERISTIC. RANGES FROM 1 THROUGH 9

3 M_i = MAXIMUM POSSIBLE COMPARATIVE SCORE FOR NON FAULT BASED SYSTEMS (TABLE 4)

4 T_i = TOTAL COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC

5 N_i = NORMALIZED COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC $\frac{T_i}{M_i}$

6 W_iN_i = WEIGHTED SCORE FOR A SYSTEM CHARACTERISTIC

7 ΣWN - MODE SCORE

8 R_N NORMALIZED MODE SCORE RANGE

9 r CORRELATION COEFFICIENT

Table 7c
MODE EVALUATION
$(W_3)_{min}$

MODE NUMBER	MODE DESIGNATION							EQUITABILITY $W_1 = 9$ $M_1 = 25$									EFFICIENCY $W_2 = 5$ $M_2 = 12$						COST $W_3 = 1$ $M_3 = 18$							EFFECTIVENESS $W_4 = 7$ $M_4 = 8$					MANAGEMENT $W_5 = 6$ $M_5 = 18$							MODE SCORE (Σ WN)
	1	2	3	4	5	6	7	1	2	3	4	5	6	T_1	N_1	W_1N_1	7	8	9	T_2	N_2	W_2N_2	10	11	12	13	T_3	N_3	W_3N_3	14	15	T_4	N_4	W_4N_4	16	17	18	19	T_5	N_5	W_5N_5	
1	1	1	1	1	1	1	1	1	1	5							1						5	4	4					3	1						4					
								2	3	4	5	4	4	22	88	7.92	4	4	3	11	.92	4.60	5	3.75	3.5	5	17.25	.96	0.96	3.5	3	6.5	.81	5.67	5	5	3.5	4	17.5	.97	5.82	25.0
2	1	1	1	1	2	1	1	1	1	5							1						3	2	3					3	3						2					
								2	3	4	5	4	4	22	88	7.92	4	4	3	11	.92	4.60	4.5	3.25	3	5	15.75	.87	0.87	3.5	3.5	7	.87	6.09	5	5	2.5	4	16.5	.92	5.52	25.0
3	1	1	1	1	2	2	1	1	1	1							1						1	1	2					5	5						1					
								2	3	2	5	4	4	20	80	7.20	4	4	3	11	.92	4.60	4	3	2.5	5	14 5	81	0.81	4	4	8	1	7.00	5	5	2	4	16	.89	5.34	25.0
4	1	1	2	1	1	1	1	3	5	5							4						5	5	5					3	1						5					
								3	4	4	5	4	4	24	.96	8.64	4.75	4	3	11 75	.98	4.90	5	4	4	5	18	1	1.00	3.5	3	6.5	.81	5.67	5	5	4	4	18	1	6.00	26.2
5	1	1	2	1	2	1	1	3	5	5							4						3	4	4					3	3						4					
								3	4	4	5	4	4	24	.96	8.64	4.75	4	3	11 75	.98	4.90	4.5	3.75	3.5	5	16.5	.92	0.92	3.5	3.5	7	.87	6.09	5	5	3.5	4	17.5	.97	5.82	26.4
6	1	1	2	1	2	2	1	3	5	1							4						1	3	3					5	5						3					
								3	4	2	5	4	4	22	.88	7.92	4.75	4	3	11 75	.98	4.90	4	3.5	3	5	15.5	.86	0.86	4	4	8	1	7.00	5	5	3	4	16.5	.92	5.52	26.2
7	1	2	1	1	1	1	1	4	1	5							2						5	3	3					3	1						4					
								3.5	3	4	5	4	4	23.5	94	8.46	4.25	4	3	11.25	.94	4.70	5	3.5	3	5	16.5	.92	0.92	3.5	3	6.5	.81	5.67	5	5	3.5	4	17.5	.97	5.82	25.6
8	1	2	1	1	2	1	1	4	1	5							2						3	2	2					3	3						2					
								3.5	3	4	5	4	4	23.5	94	8.46	4.25	4	3	11.25	.94	4.70	4.5	3.25	2.5	5	15.25	.85	0.85	3.5	3.5	7	.87	6.09	5	5	2.5	4	16.5	.92	5.52	25.6
9	1	2	1	1	2	2	1	4	1	1							2						1	1	1					5	5						1					
								3.5	3	2	5	5	4	21.5	.86	7.74	4.25	4	3	11.25	.94	4.70	4	3	2	5	14	.78	0.83	4	4	8	1	7.00	5	5	2	4	16	[illegible]	5.34	25.6
10	1	2	2	1	1	1	1	5	5	5							5						5	5	4					3	1						5					
								4	4	4	5	4	4	25	1	9.00	5	4	3	12	1	5.00	5	4	3.5	5	17.5	.97	0.97	3.5	3	6.5	.81	5.67	5	5	4	4	18	1	6.00	26.6
11	1	2	2	1	2	1	1	3	3	3							5						3	4	3					3	3						4					
								4	4	4	5	4	4	25	1	9.00	5	4	3	12	1	5.00	4.5	3.75	3	5	16.25	.90	0.90	3.5	3.5	7	.87	6.09	5	5	3.5	4	17.5	.97	5.82	26.8
12	1	2	2	1	2	2	1	5	5	1							5						1	3	2					5	5						3					
								4	4	2	5	4	4	23	.92	8.28	5	4	3	12	1	5.00	4	3.5	2.5	5	15	.83	0.83	4	4	8	1	7.00	5	5	3	4	17	.94	5.64	26.8

$R_N = .07$

NDTES

1 FOR EACH SYSTEM NUMBER. THE TOP AND LOWER ROW ENTRIES ARE RAW SCORES AND COMPARATIVE SCORES RESPECTIVELY. RAW SCORES ARE FROM 1 (POOR) TO 5 (GOOD). COMPARATIVE SCORES ARE SCALED TO THE SCORES OF TABLE 4.

2. W_i = WEIGHT ASSOCIATED WITH SYSTEM CHARACTERISTIC. RANGES FROM 1 THROUGH 9

3 M_i = MAXIMUM POSSIBLE COMPARATIVE SCORE FOR NON FAULT BASED SYSTEMS (TABLE 4)

4 T_i = TOTAL COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC

5 N_i = NDRMALIZED COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC = $\frac{T_i}{M_i}$

6 W_iN_i = WEIGHTED SCORE FOR A SYSTEM CHARACTERISTIC

7 Σ WN - MODE SCORE

8 R_N NORMALIZED MODE SCORE RANGE

9 r - CORRELATION COEFFICIENT

Table 7d

MODE EVALUATION

$(W_3)_{max}$

MODE NUMBER	MODE DESIGNATION							EQUITABILITY W_1 = 8 M_1 = 25									EFFICIENCY W_2 = 5 M_2 = 12						COST W_3 = 9 M_3 = 18							EFFECTIVENESS W_4 = 7 M_4 = 8					MANAGEMENT W_5 = 5 M_5 = 18							MODE SCORE (Σ WN)
	1	2	3	4	5	6	7	1	2	3	4	5	6	T_1	N_1	W_1N_1	7	8	9	T_2	N_2	W_2N_2	10	11	12	13	T_3	N_3	W_3N_3	14	15	T_4	N_4	W_4N_4	16	17	18	19	T_5	N_5	W_5N_5	
1	1	1	1	1	1	1	1	1	1	5							1						5	4	4					3	1						4					
								2	3	4	5	4	4	22	.88	7.04	4	4	3	11	.92	4.60	5	3.75	3.5	5	17.25	.96	8.64	3.5	3	6.5	.81	5.67	5	5	3.5	4	17.5	.97	4.85	30.8
2	1	1	1	1	2	1	1	1	1	5							1						3	2	3					3	3						2					
								2	3	4	5	4	4	22	.88	7.04	4	4	3	11	.92	4.60	4.5	3.25	3	5	15.75	.87	7.83	3.5	3.5	7	.87	6.09	5	5	2.5	4	16.5	.92	4.60	30.2
3	1	1	1	1	2	2	1	1	1	1							1						1	1	2					5	5						1					
								2	3	2	5	4	4	20	.80	6.40	4	4	3	11	.92	4.60	4	3	2.5	5	14.5	.81	7.29	4	4	8	1	7.00	5	5	2	4	16	.89	4.45	29.7
4	1	1	2	1	1	1	1	3	5	5							4						5	5	5					3	1						5					
								3	4	4	5	4	4	24	.96	7.68	4.75	4	3	11.75	.98	4.90	5	4	4	5	18	1	9.00	3.5	3	6.5	.81	5.67	5	5	4	4	18	1	5.00	31.9
5	1	1	2	1	2	1	1	3	5	5							4						3	4	4					3	3						4					
								3	4	4	5	4	4	24	.96	7.68	4.75	4	3	11.75	.98	4.90	4.5	3.75	3.5	5	16.5	.92	8.28	3.5	3.5	7	.87	6.09	5	5	3.5	4	17.5	.97	4.85	31.8
6	1	1	2	1	2	2	1	3	5	1							4						1	3	3					5	5						3					
								3	4	2	5	4	4	22	.88	7.04	4.75	4	3	11.75	.98	4.90	4	3.5	3	5	15.5	.86	7.74	4	4	8	1	7.00	5	5	3	4	16.5	.92	4.60	31.3
7	1	2	1	1	1	1	1	4	1	5							2						5	3	3					3	1						4					
								3.5	3	4	5	4	4	23.5	.94	7.52	4.25	4	3	11.25	.94	4.70	5	3.5	3	5	16.5	.92	8.28	3.5	3	6.5	.81	5.67	5	5	3.5	4	17.5	.97	4.85	31.0
8	1	2	1	1	2	1	1	4	1	5							2						3	2	2					3	3						2					
								3.5	3	4	5	4	4	23.5	.94	7.52	4.25	4	3	11.25	.94	4.70	4.5	3.25	2.5	5	15.25	.85	7.65	3.5	3.5	7	.87	6.09	5	5	2.5	4	16.5	.92	4.60	30.6
9	1	2	1	1	2	2	1	4	1	1							2						1	1	1					5	5						1					
								3.5	3	2	5	5	4	21.5	.86	6.88	4.25	4	3	11.25	.94	4.70	4	3	2	5	14	.78	6.48	4	4	8	1	7.00	5	5	2	4	16	.89	4.45	29.5
10	1	2	2	1	1	1	1	5	5	5							5						5	5	4					3	1						5					
								4	4	4	5	4	4	25	1	8.00	5	4	3	12	1	5.00	5	4	3.5	5	17.5	.97	8.73	3.5	3	6.5	.81	5.67	5	5	4	4	18	1	5.00	32.4
11	1	2	2	1	2	1	1	3	3	3							5						3	4	3					3	3						4					
								4	4	4	5	4	4	25	1	8.00	5	4	3	12	1	5.00	4.5	3.75	3	5	16.25	.90	8.10	3.5	3.5	7	.87	6.09	5	5	3.5	4	17.5	.97	4.85	32.0
12	1	2	2	1	2	2	1	5	5	1							5						1	3	2					5	5						3					
								4	4	2	5	4	4	23	.92	7.36	5	4	3	12	1	5.00	4	3.5	2.5	5	15	.83	7.02	4	4	8	1	7.00	5	5	3	4	17	.94	4.70	31.1

R_N = .09

NOTES

1 FOR EACH SYSTEM NUMBER. THE TOP AND LOWER ROW ENTRIES ARE RAW SCORES AND COMPARATIVE SCORES, RESPECTIVELY RAW SCORES ARE FROM 1 (POOR) TO 5 (GOOD). COMPARATIVE SCORES ARE SCALED TO THE SCORES OF TABLE 4 .

2 W_i = WEIGHT ASSOCIATED WITH SYSTEM CHARACTERISTIC; RANGES FROM 1 THROUGH 9

3. M_i = MAXIMUM POSSIBLE COMPARATIVE SCORE FOR NON FAULT BASED SYSTEMS (TABLE 4)

4 T_i = TOTAL COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC

5 N_i = NORMALIZED COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC = $\frac{T_i}{M_i}$

6. W_iN_i = WEIGHTED SCORE FOR A SYSTEM CHARACTERISTIC

7. ΣWN = MODE SCORE

8. R_N = NORMALIZED MODE SCORE RANGE

9 r = CORRELATION COEFFICIENT

Table 7e
MODE EVALUATION
$W_1=W_2=W_3=W_4=W_5$

MODE NUMBER	MODE DESIGNATION							EQUITABILITY $W_1 = 1$ $M_1 = 25$									EFFICIENCY $W_2 = 1$ $M_2 = 12$						COST $W_3 = 1$ $M_3 = 18$							EFFECTIVENESS $W_4 = 1$ $M_4 = 8$					MANAGEMENT $W_5 = 1$ $M_5 = 18$							MODE SCORE (Σ WN)
	1	2	3	4	5	6	7	1	2	3	4	5	6	T_1	N_1	W_1N_1	7	8	9	T_2	N_2	W_2N_2	10	11	12	13	T_3	N_3	W_3N_3	14	15	T_4	N_4	W_4N_4	16	17	18	19	T_5	N_5	W_5N_5	
1	1	1	1	1	1	1	1	1	1	5							1						5	4	4					3	1						4					
								2	3	4	5	4	4	22	.88		4	4	3	11	.92		5	3.75	3.5	5	17.25	96		3.5	3	6.5	.81		5	5	3.5	4	17.5	.97		4.54
2	1	1	1	1	2	1	1	1	1	5							1						3	2	3					3	3						2					
								2	3	4	5	4	4	22	.88		4	4	3	11	.92		4.5	3.25	3	5	15.75	.87		3.5	3.5	7	.87		5	5	2.5	4	16.5	.92		4.46
3	1	1	1	1	2	2	1	1	1	1							1						1	1	2					5	5						1					
								2	3	2	5	4	4	20	.80		4	4	3	11	.92		4	3	2.5	5	14.5	81		4	4	8	1		5	5	2	4	16	.89		4.42
4	1	1	2	1	1	1	1	3	5	5							4						5	5	5					3	1						5					
								3	4	4	5	4	4	24	.96		4.75	4	3	11.75	.98		5	4	4	5	18	1		3.5	3	6.5	.81		5	5	4	4	18	1		4.75
5	1	1	2	1	2	1	1	3	5	5							4						3	4	4					3	3						4					
								3	4	4	5	4	4	24	.96		4.75	4	3	11.75	.98		4.5	3.75	3.5	5	16.5	.92		3.5	3.5	7	.87		5	5	3.5	4	17.5	.97		4.70
6	1	1	2	1	2	2	1	3	5	1							4						1	3	3					5	5						3					
								3	4	2	5	4	4	22	.88		4.75	4	3	11.75	.98		4	3.5	3	5	15.5	.86		4	4	8	1		5	5	3	4	16.5	.92		4.64
7	1	2	1	1	1	1	1	4	1	5							2						5	3	3					3	1						4					
								3.5	3	4	5	4	4	23.5	.94		4.25	4	3	11.25	.94		5	3.5	3	5	16.5	.92		3.5	3	6.5	.81		5	5	3.5	4	17.5	.97		4.58
8	1	2	1	1	2	1	1	4	1	5							2						3	2	2					3	3						2					
								3.5	3	4	5	4	4	23.5	.94		4.25	4	3	11.25	.94		4.5	3.25	2.5	5	15.25	.85		3.5	3.5	7	.87		5	5	2.5	4	16.5	.92		4.52
9	1	2	1	1	2	2	1	4	1	1							2						1	1	1					5	5						1					
								3.5	3	2	5	5	4	21.5	.86		4.25	4	3	11.25	.94		4	3	2	5	14	.78		4	4	8	1		5	5	2	4	16	.89		4.47
10	1	2	2	1	1	1	1	5	5	5							5						5	5	4					3	1						5					
								4	4	4	5	4	4	25	1		5	4	3	12	1		5	4	3.5	5	17.5	.97		3.5	3	6.5	.81		5	5	4	4	18	1		4.78
11	1	2	2	1	2	1	1	3	3	3							5						3	4	3					3	3						4					
								4	4	4	5	4	4	25	1		5	4	3	12	1		4.5	3.75	3	5	16.25	.90		3.5	3.5	7	.87		5	5	3.5	4	17.5	.97		4.74
12	1	2	2	1	2	2	1	5	5	1							5						1	3	2					5	5						3					
								4	4	2	5	4	4	23	.92		5	4	3	12	1		4	3.5	2.5	5	15	.83		4	4	8	1		5	5	3	4	17	.94		4.69

$R_N = .08$

NOTES

1 FOR EACH SYSTEM NUMBER. THE TOP AND LOWER ROW ENTRIES ARE RAW SCORES AND COMPARATIVE SCORES. RESPECTIVELY RAW SCORES ARE FROM 1 (POOR) TO 5 (GOOD). COMPARATIVE SCORES ARE SCALED TO THE SCORES OF TABLE 4

2 W_i = WEIGHT ASSOCIATED WITH SYSTEM CHARACTERISTIC; RANGES FROM 1 THROUGH 9

3. M_i = MAXIMUM POSSIBLE COMPARATIVE SCORE FOR NON FAULT BASED SYSTEMS (TABLE 4)

4 T_i = TOTAL COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC

5 N_i = NORMALIZED COMPARATIVE SCORE FOR A SYSTEM CHARACTERISTIC = $\frac{T_i}{M_i}$

6 W_iN_i = WEIGHTED SCORE FOR A SYSTEM CHARACTERISTIC

7 Σ WN · MODE SCORE

8 R_N NORMALIZED MODE SCORE RANGE

9 r CORRELATION COEFFICIENT

Table 8

MODE SCORE SUMMARY

WEIGHT SELECTION	HIGH MODE SCORE	LOW MODE SCORE	NORMALIZED MODE RANGE	TABLE NO.
	MODE NO.	MODE NO.	R_N	
$(\Sigma r)_{MAX}$	11	3	0.07	7 a
$(\Sigma v)_{MIN}$	10	3	0.10	b
$(W_3)_{MIN}$	11, 12	1, 2, 3	0.07	c
$(W_3)_{MAX}$	10	9	0.09	d
$W_1 = W_2 = W_3 = W_4 = W_5$	10	3	0.08	e

tion, the specific award would be tailored to the individual and his total losses. That is, since the basis for the award is the damages and losses incurred by the claimant, the amount provided would be commensurate with the losses to that individual. Associated with the award, it appears desirable and equitable to make payment on a periodic basis, that is, monthly, quarterly or annually. By providing payment on a periodic basis it is feasible to make adjustments for both changes (up or down) in the losses related to the medical injury and changes (improvement or deterioration) in the condition for which compensation was awarded. The review of the losses and the medical condition would be made annually by the Medical Injury Compensation Commission.

SUMMARY DESCRIPTION OF RECOMMENDED MODE

All of the modes considered in the foregoing evaluation and selection have been based on the establishment of a State Medical Injury Compensation Commission which directs a Medical Injury Compensation Board in accordance with a Medical Injury Compensation Law. Further, all modes are based on the assumption that the law is based on the principle of strict liability and contains explicit definitions of compensable medical injury. The costs of administering the Medical Injury Compensation Commission are borne by general taxes; all other costs are borne by insurance.

The mode which is recommended as the most appropriate (at least for the immediate future) of the non-fault-based modes considered and which also appears to possess system characteristics which are distinctly superior to tort-liability and total social security compensation system is described below. In the notation adopted in the analysis the selected mode is designated 1221121. The following description follows the order of its element forms.

1) The system will be compulsory in the sense that it abolishes relief for compensable medical injury through tort-liability.

2) Claims may be filed by the injured party (or his representative). Assistance is provided through the Board in filing claims and (for hospital patients) in uncovering potential claims, although the decision to file still rests with the claimant.

3) A claim-screening mechanism functions to informally review all claims at an early stage. As a result, the abandonment of nonmeritorious claims is encouraged, probably successful claims are supported; and settlement without further formal procedure is advised in non-disputed cases.

4) Claims not disposed of in the preceding screening stage advance to the referee (or hearing examiner) who, with the aid of expert medical staff, hears argument by claimant, health care providers and their advisors. The referee determines compensability based on the evidence presented to him and in accordance with the rules of the Commission.

5) Compensability is limited to special damages which include all costs incurred in treating the injury, loss of income, including present worth of future income, compensation for disabilities resulting from the injury, and rehabilitation.

6) The referee, usually at the hearing outlined under (4) above, also determines the amount of compensation awarded. To the extent possible, he makes the award following schedules which are established by the Commission. Where schedules do not apply he uses his own, or additionally, his medical advisor's judgment in making the award.

7) Claimant, health care providers and their insurance carriers may appeal the referee's decision to a Commission Review Board which examines questions of law and

Table 9

COMPARISON OF TORT-LIABILITY AND THREE NON-FAULT-BASED MEDICAL INJURY COMPENSATION SYSTEMS

	SYSTEM DESIGNATION							EQUITABILITY $W_1 = 9$ $T_{i_{max}} = 30$									EFFICIENCY $W_2 = 4$ $T_{2_{max}} = 15$						COST $W_3 = 3$ $T_{3_{max}} = 20$							EFFECTIVENESS $W_4 = 7$ $T_{4_{max}} = 10$					MANAGEMENT $W_5 = 5$ $T_{5_{max}} = 20$							SCORE
	1	2	3	4	5	6	7	1	2	3	4	5	6	T_1	N_1	W_1N_1	7	8	9	T_2	N_2	W_2N_2	10	11	12	13	T_3	N_3	W_3N_3	14	15	T_4	N_4	W_4N_4	16	17	18	19	T_5	N_5	W_5N_5	Σ WN
NON-FAULT-BASED	1	2	2	1	1	2	1	4	4	2	5	4	4	23	.77	6.93	5	4	3	12	.80	3.20	4.5	3.75	3.5	5	16.75	.84	2.52	4	3.5	7.5	.75	5.25	5	5	4	4	18	.90	4.50	22.4
	1	2	2	1	2	2	1	4	4	2	5	4	4	23	.77	6.93	5	4	3	12	.80	3.20	4	3.5	2.5	5	15	.75	2.75	4	4	8	.80	5.60	5	5	3	4	17	.85	4.25	22.2
	1	2	2	1	2	1	1	4	4	4	5	4	4	25	.83	7.45	5	4	3	12	.80	3.20	4.5	3.75	3	5	16.25	.81	2.43	3.5	3.5	7	.70	4.90	5	5	3.5	4	17.5	.88	4.40	22.4
TORT-LIABILITY	LOW EFFECTIVENESS							1	1	1	3	3	1	10	.33	3.00	3	1	1	5	.33	1.33	1	2	5	1	9	.45	1.35	2	2	4	.40	2.80	1	1	5	1	8	.40	2.00	10.5
	HIGH EFFECTIVENESS							1	1	1	3	3	1	10	.33	3.00	3	1	1	5	.33	1.33	1	2	5	1	9	.45	1.35	5	5	10	1.0	7.00	1	1	5	1	8	.40	2.00	14.7

NOTES:
(1) WEIGHTS (W) USED ARE THOSE THAT HAVE THE HIGHEST CORRELATION AMONG JUDGES
(2) $T_{i_{max}}$ = MAXIMUM POSSIBLE COMPARATIVE SCORE FOR SYSTEM COMPARISON

fact. The decision of the Review Board may be further appealed to court of law, but only on questions of procedure.

Incorporated in the recommended injury compensation system, which includes this mode, is provision for keeping a written record. This record will be used as a basis for a continuing process of improving the Commission's rules.

5. Proposed Major Provisions of a Medical Injury Compensation Act

PART I—GENERAL PROVISIONS

SECTION 1. *Short title.* This act shall be known as the "Medical Injury Compensation Act."

SECTION 2. *Purpose.* The purpose of this act is to establish a system of prompt, efficient, and equitable compensation to those persons injured through medical intervention.

SECTION 3. *Definitions.* As used in this act:

(1) "Compensable injury" is defined as any physical harm, bodily impairment, disfigurement, or delay in recovery which (i) is more probably associated in whole or in part with medical intervention rather than with the condition for which such intervention occurred, and (ii) is not consistent with or reasonably to be expected as a consequence of such intervention, or (iii) is a result of medical intervention to which the patient has not consented.

(2) "Physical harm" shall include wounds, infections, disease or death.

(3) "Bodily impairment" shall include temporary or permanent impairment or loss of bodily functions, bodily parts, mental or emotional processes, or behavioral controls. [Note: The bodily impairment description may be adjusted to exclude mental or emotional processes, or behavioral controls.]

(4) "Disfigurement" shall include scars or adverse changes in bodily appearance beyond those which are medically required.

(5) "Delay in recovery" shall include any undue additional time spent under care not substantially attributable to the condition for which medical intervention occurred and shall include consideration of the general health of the patient.

(6) "Medical intervention: shall include the rendering, as well as the omission, of any care, treatment or services provided within the course of treatment administered by, or under the control of, a health care provider or within a health care institution.

(7) "Condition" shall include the general state of health of the patient prior to medical intervention.

SECTION 4. *Tort liability abolished.* Tort liability arising from a compensable injury as defined herein is abolished.

SECTION 5. *Health care providers and health care institutions: insurance requirements.* All health care providers and health care institutions shall maintain at all times insurance which provides for payment by the insurer of at least those benefits required under this act.

PART II—BENEFITS

SECTION 6. *Required benefits.* Every policy of insurance required by this act to be maintained by health care providers and health care institutions shall provide the following payments for compensable injuries:

(1) Medical, hospital and dental expenses;
(2) Lost earnings;
(3) Present worth of future loss of earnings;
(4) Rehabilitation.

SECTION 7. *Collateral sources of indemnity.* All required benefits shall be paid net of the amount of any benefit payable by reason of the compensable injury resulting from the occurrence which gives rise to the benefit under the United States Social Security Act, any state or federal income disability or workmen's compensation law, any accident, health, sickness, or disability insurance, and any contract or agreement by any group, organization, partnership, or corporation to provide or to pay for or reimburse the cost of medical, hospital, dental, or other services included in the required benefits under this act. Nothing in this section shall prevent any person from expressly insuring against, and receiving payment for, damages in excess of those included in the required benefits under this act.

PART III—DETERMINATION OF COMPENSABILITY AND COMPENSATION

SECTION 8. *Claims initiation.* Any person claiming to be aggrieved under this act shall submit information concerning his claim on forms to be provided by the designated claims screening agency.

SECTION 9. *Claims screening agency.* The designated claims screening agency shall examine such claim and determine whether reasonable cause exists to believe a compensable injury occurred. Should reasonable cause be found, the claim, together with supporting materials, shall be forwarded to the designated hearing examiner. Should, however, reasonable cause not be found, a claimant, within thirty (30) days after notice from the designated claims screening agency, may proceed independently before the designated hearing examiner.

SECTION 10. *Determination by hearing examiner.* The designated hearing examiner shall have full power and authority to determine all questions in relation to the payment of claims presented under this act. The designated hearing examiner shall make or cause to be made such investigation as it deems necessary, and upon application of either party shall order a hearing, and within thirty (30) days after a claim is submitted under this act, or such hearing closed, shall make or deny an award concerning such claim.

SECTION 11. *Appeal to review panel.* Within thirty (30) days after notice of an award or a denial thereof by the hearing examiner, any party in interest may appeal to a designated review panel. Such review panel shall have plenary powers to review all questions of law and fact appearing in the record of the proceedings before the hearing examiner.

SECTION 12. *Judicial review.* Within thirty (30) days after notice of decision by the designated review panel, an appeal may be taken thereafter by any party in interest to the designated judicial forum. The judicial forum shall consider all findings of facts below to be conclusive if supported by substantial evidence in the record.

Commentary

PART I—GENERAL PROVISIONS

Although this act abolishes liability in tort for both negligence and battery (SECTION 4.), it does not dispense with the requirement that medical intervention be causally related to a compensable injury. The chosen standard for causality is a common law one appropriate to civil actions in general, viz., a preponderance of the evidence. *See*, Devitt and Blackmar, *Federal Jury Practice and Instructions*, Sec. 71.01 (1970) ("... such evidence as, when considered and compared to that opposed to it, ... produces ... belief that what is sought to be proved is more likely true than not true."). However, to avoid a denial of recovery where medical intervention may have caused only a portion of the compensable injury, the standard has been relaxed to allow recovery for compensable injuries "... more probably associated in whole or in part with medical intervention ..." (SECTION 3 (1)). This relaxation of standards is analogous to the Federal Employer's Liability Act which allows recovery for personal injuries "... resulting in whole or in part from the negligence of the officers, agents, or employees of such carrier ...". 45 U. S. C. A. Sec. 51 (1972).

The chosen vehicle for funding is one of insurance to be maintained by both health care providers and health care institutions. It is beyond the scope of the act or this commentary to delineate the specifics of such an insurance system. However, State Workmen's Compensation Acts provide one model, and "no-fault" automobile accident statutes provides another.

PART II—BENEFITS

Absent from required benefits is recovery for "pain and suffering". This reflects the policy decision of the study group and supporting reasons are enumerated in the Report.

Recovery for bodily impairment and disfigurement would be in accord with schedules. Drafting of such schedules is beyond the scope of the act and this commentary.

Recovery for loss of earnings is envisioned as recovery for actual economic losses. Thus, as contemplated, there would be no scheduled percentage or limitation—a common feature of workmen's compensation acts. Payment for present worth of future loss of earnings could be changed to periodic payments for future loss of earnings.

Since compensation is the keynote of this act, there is no policy reason to prevent deducting from recovery collateral sources of indemnity. The rationale of tort systems preventing such collateral indemnity rests upon a premise that collateral indemnification results in a windfall to the tort feasor.

PART III—DETERMINATION OF COMPENSABILITY AND COMPENSATION

Responsibility for initiation of the claim rests with the claimant. It is anticipated, however, that the existence of the statutory remedy and procedure will be widely publicized so that the probability that medically-injured persons will be aware of the available remedy will be great. Health care recipients will be notified if potential claims for compensable injuries are found by the claims screening agency upon review of hospital records. Assistance of personnel of the designated claims screening agency will be available to aid claimants in filling out the form and following the designated procedure. The final decision, however, to file a claim will be left to the medically-injured person.

Utilization of the claims screening mechanism is compulsory. Procedures to be adopted will be largely informal. Whether or not the calling of witnesses and taking of testimony will be necessary will depend upon the facts of each individual case. Participants before the designated claims screening agency may include the claimant, the health-care provider and the insurer. A formal hearing is not contemplated and participation may be written or recorded verbal communication. The participation of legal counsel acting on behalf of the claimant, health-care provider or insurer, is not contemplated, although such participation is not barred. All parties in interest will be advised of the merits of the claim as perceived by the designated claims screening agency and early disposition by settlement will be facilitated. A positive finding of reasonable cause will not be appealable by the health-care provider or insurer at this stage of the proceeding; review of their grievances, if any, will not take place until the claim has reached the stage of Section 11, Appeal to Review Panel. A negative finding does not preclude the claimant since he may proceed independently to the stage in the procedure contemplated by Section 10, Determination by Hearing Examiner. In the interest of finality and the planning interests of the health care providers and insurers, the claimant is required to take the next step in the procedure, i.e., proceeding independently to the designated hearing examiner, within thirty (30) days after notice from the claims screening agency that a finding of no reasonable cause has been entered. If the claimant fails to take this step his claim is barred. Allowance should be made, however, by statute or regulation, for re-opening of the case at this point by the claimant if he can demonstrate justification for his failure to proceed within the thirty (30) day period. It will be the responsibility of the designated claims screening agency to make every reasonable effort to inform claimants of their statutory right to proceed independently to the designated hearing examiner.

The hearing examiner will determine first the question of compensability and then, if the finding is positive, the question of compensation. He will possess full judicial powers, including the power to issue compulsory process and the power of contempt for failure to obey interlocutory orders. A formal administrative hearing comporting fully with state and federal requirements of procedural due process is contemplated. No award shall issue except upon completion of a formal hearing. It should be noted, however, that a hearing shall not be ordered by the designated hearing officer except upon application of a party in interest. Thus, even though there is a finding of reasonable cause by the designated claims screening agency and the claim is forwarded to the designated hearing examiner, the burden is upon the claimant, health-care provider or insurer to make application for the formal hearing. This is to insure, as a matter of policy, that claim adjudication will take place only upon the initiative of an interested party and will not follow automatically upon the filing of a claim and a finding of reasonable cause by the designated claims screening agency. In cases where a finding of no reasonable cause has been made by the designated claims screening agency, the independent procession of the claimant to the designated hearing examiner will constitute an application for a hearing. No formal requirements will be established for the mode of effecting the independent processing or other application for a hearing; written or recorded verbal communication will suffice. Participants at the hearing will include the claimant, health-care provider and insurer. The participation of legal counsel acting on behalf of the claimant, health-care provider or insurer, is contemplated but not required. As a matter of policy, claimants will be advised of their right to counsel and counsel will be provided for indigent claimants on request. (Note that such policy will avoid the troublesome question of whether state and federal due process and equal protection principles require the presence of counsel in administrative and quasi-judicial proceedings). All claimants will be assisted in securing medical expert testimony and such assistance will be provided without cost to indigent claimants.

The appeal by a party in interest to the designated review panel (Section 11) does not contemplate a *de novo* hearing at which the parties would be permitted to present new or additional evidence. The review is limited to the record. The extent of advocacy permitted by a party in interest is that of oral argument and submission of written points. Participants shall include the claimant, health-care provider and insurer. Again, the participation of legal counsel acting on behalf of the claimant, health-care provider or insurer, is contemplated but not required. Also again, and as a matter of policy, claimants will be advised of their right to counsel and counsel will be provided for indigent claimants on request. Since it is at this point that the advocacy of counsel for health-care providers or insurers may tend to formality and technical argument, it will be discretionary with the designated review panel to appoint counsel for indigents and non-indigents alike without specific request therefor. The regulations of the designated review panel should encourage a liberal exercise of discretion to avoid constitutional issues on judicial review pertaining to the right to counsel and adequacy of waiver.

The designated judicial forum may be the court statutorily empowered in the particular state ot hear appeals from state administrative agencies, or it may be the court empowered to hear appeals in Workmen's Compensation cases, if that is a different court. The particular designation is left to the individual states. It is beyond the scope of this commentary to recommend the proper judicial forum. It is contemplated, however, that the usual burden of proof in appeals from administrative agencies will prevail with respect to findings of facts below: substantial evidence in the record. Beyond this the scope of judicial review will be limited to a review of procedural errors only.

It should be noted that enactment of the act may necessitate coordinate amendments to statutes of civil procedure in the various states pertaining to appeals from administrative agencies.

Finally, it should also be noted that the composition and formation of the claims screening agency, hearing examiner and review panel has been left to the several states enacting such legislation and is considered beyond the scope of this commentary.

6. Recommended Further Research and Implementation

In principle, and in limited specificity, the merits of the recommended non-fault-based medical injury compensation system as an alternative to the current fault-liability system have been demonstrated. Given that the analogy of this compensation system to the Workmen's Compensation System is appropriate, and in recognition of certain limitations of the latter system for compensating employees, it has been stated that the non-fault-based system contains the appropriate remedies being sought after by the patient-claimant, the health care providers, the insurance carriers and the public-at-large. However, before this form of compensation system can be implemented by the legislatures, there are a number of significant issues which require further study so as to better insure the successful implementation of such an alternative. The premature and ill-conceived implementation of this recommended compensation system could result in greater difficulties than maintaining the tort-liability system in spite of its many deficiencies.

This section is devoted to a number of considerations which should be addressed in further research, as well as the recommendation for several pilot demonstration projects. Although several of the areas discussed are related to aspects of medical *malpractice* as well as with medical *practice*, they are included because of their relationships to the problem of compensation.

SPECIFICATION OF MEDICAL INTERVENTION OUTCOME MEASURES

As indicated in Section 3 of this Report, significant effort was allocated within this project, as well as by others, to the development of a scheme for measuring the outcomes of medical intervention, and to the relationship of outcomes to the determination of compensable medical injury. Whereas conceptually this approach appeared both rational and feasible, its actual specification was extremely difficult. Thus, the definition of compensable (medical) injury adopted in this study contains a combination of process and outcome measures, and entails, in some cases, a relatively high degree of subjectivity in making the determination.

It is our belief, along with others such as Carlson[11] that the development of a scheme for measuring the results of health care, in an objective and statistically-valid manner, would be beneficial for both quality assurance as well as compensation purposes. The potential benefits to be derived from the establishment of such a system of output measures would be to assist in standardizing the treatment of patients falling within well-defined diagnostic classes, to reduce the incidence of defensive medicine, and to have a more precise gauge for measuring the results of medical care. The implementation of such a system would require (a) pilot research and test programs to study the outcomes assessment problem in a well-defined limited setting, say, certain routine surgical procedures, (b) an estimate of the time and funding requirements of a comprehensive outcomes assessment project, and (c) the investigation of requirements for modifications in medical record keeping procedures and the setting-up of a central source for gathering, analyzing and disseminating the experience.

ESTIMATION OF MAGNITUDE BY TYPES OF MEDICALLY-INDUCED INJURIES INCORPORATED WITHIN SPECIFIED NON-FAULT-BASED SYSTEMS

An effort was made by the Secretary's Commission to obtain estimates of the number of patients injured in the course of treatment[12]. Each of these endeavors provided partial results toward deriving a better estimate of the number of patients who incurred injuries which may or may not have been known to the patient, or reported by the health care provider to the insurance carrier, and resulted in some form of disposition. Thus, although better inputs are made available for making estimates of the number of patients receiving injuries, and the relationship of the injury and its severity to the disposition of a claim, there is still a significant gap in knowledge.

In part because of the absence of good base-line estimates pertaining to the number and types of injuries and their dispositions within the fault-liability system of compensation, it was not possible to derive meaningful estimates of magnitude of compensable medical injuries and associated compensation costs within the recommended non-fault-based compensation system. The need for this information is related to such important tasks as (1) specifying funding alternatives; (2) setting rates and premiums; (3) establishing the appropriate organizational structure and operational procedures for efficiently handling the number of claimants.

An analytic study, along with a significant data collection effort, is required to establish the data requirements, the collection techniques to be utilized and the Implementation characteristics for a Federally-supported Nationwide data collection and analysis capability. This study should take into some consideration the needs of the insurance carriers and some of the other uses of this type of information, particularly those estimates involved with quality assurance considerations or health care delivery.

IMPROVEMENT OF MEDICALLY-INJURED PATIENT AWARENESS

Within a non-fault-based medical injury compensation system there should be less reluctance on the part of the health care providers and institutions to make information available to the medically-injured patient. Additionally, if the system funding is provided by a combination of the health care providers and institutions along with the patients (directly) there is a still greater incentive and rationale for notifying the patient that he may have incurred a compensable medical injury.

A major step in this direction is the Commission's recommendations that there be established patient grievance mechanisms in all health care institutions and, to the degree possible, in non-institutional settings. Although the recommendation does not specifically call out the function of informing the patient that he may have been medically-injured, they do mention the overall function of "dealing with patient care problems". The need for such specific assistance is particularly important among the economically poor, ill-informed, and poorly educated segments of the population.

A study of alternative forms of informing the public-at-large and, in particular, patients, while undergoing medical interventions, should be instituted, along with examining various approaches to providing assistance in the claim initiation and handling stages.

EXAMINATION OF LEGAL ISSUES ASSOCIATED WITH A NON-FAULT-BASED COMPENSATION SYSTEM

During the course of this study, a number of significant legal considerations became evident but could not be dealt with to the degree that is required before such a compensation system could be legislated. Among the most significant questions which require legal research and opinion are:

- Can a non-fault-based medical injury compensation system be established as a complete replacement for the current tort-liability system?

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[11] *Ibid.*

[12] "The Incidence of Iatrogenic Injuries"; "Medical Injuries Described in Hospital Patient Records"; "Medical Malpractice Insurance Claims Files Closed in 1970"; "Consumers' Knowledge of and Attitudes Toward Medical Malpractice."

- Should the recommended system regulate the practice of attorneys in terms of fee structure and their availability within this system, as is being done to some degree under the Workmen's Compensation System?
- Given that all medical injury compensation would be handled within the recommended non-fault-based system, how should collateral sources of compensation be treated?
- What rights and forms of appeal should be made available to claimants who are not satisfied with the handling and disposition of their claims within the non-fault-based system?

Each of these issues requires in-depth analysis rather than relying solely on the experience derived from the Workmen's Compensation System.

ESTABLISHMENT OF SCHEDULES OF COMPENSATION

Among the limitations of the tort-liability system (as cited in Section 2) is the inequity pertaining to the amount of compensation awarded under similar injuries and circumstances. As part of our recommended system, it is suggested that awards be made using a schedule for establishing losses incurred. It is recognized that the early implementation of the medical injury compensation system would require a rather substantial reliance on judgment in establishing appropriate award levels. However, it is expected that with the passing of time and the systematic gathering of information pertaining to injuries, circumstances and awards, less dependence would be placed on judgment and greater systemization could be achieved. This conviction is based, in part, on the history and experience of most state Workmen's Compensation Systems.

It is recommended that efforts be initiated to establish a comprehensive and internally consistent set of schedules for compensating the medically injured under a non-fault-based system for specific damages, and a codified procedure for individualizing these awards based on the specific and particular circumstances of the individual claimant.

ASSESSMENT OF ALTERNATIVE METHODS OF SYSTEM FUNDING

There is a prevalent feeling among health care providers and institutions that the monetary burden of maintaining professional liability insurance should not be placed on them exclusively. In actuality, although they do pay the premium for this form of insurance, the funds are derived from the patients and the cost of professional liability coverage is considered by the practitioners and institutions in establishing their fees for service. As a portion of our recommendations, we cite a specific funding alternative which would incorporate the current parties, as well as the patients and the public-at-large.

The suggested system funding proposal is based on the principle of providing each of the above segments a greater sense of participating within the compensation system and thereby modifying the attitudes of the affected individuals concerning the initiation of a claim and the receipt of an award. In some measure, it is believed that broadening the base of system funding would alleviate the adversarial feelings during and after the compensation process.

An examination, in some detail, is required of alternative methods of funding within the above stated principle and the establishment of specific recommendations concerning the insurance mechanisms, processes and premiums which would be most appropriate to the non-fault-based system.

RELATIONSHIPS BETWEEN HEALTH CARE DELIVERY QUALITY ASSURANCE AND NON-FAULT-BASED MEDICAL INJURY COMPENSATION

Some of the proponents of the current tort-liability approach for compensating the medically-injured allege that the existence of this fault-based system improves the quality of health care because of the constant threat it represents to the health care providers and institutions. We recognize the potential ill effect of removing this deterrent by substituting a non-fault-based compensation system. Nevertheless the coupling of the recommended compensation system with a quality assurance program appears highly contradictory. Therefore, our recommendation is to separate these two aspects of health care delivery. It is our position that medical injury data be collected, analyzed and made available on aggregated basis to whatever organizations and mechanisms may be established for quality assurance purposes.

A study is required to examine the relationships between the quality assurance programs and the compensation system so as to establish the forms and types of aggregated data which should be shared by both and still maintain the necessary separation of responsibilities and functions.

SELECTION AND SPECIFICATION OF NON-FAULT-BASED MEDICAL INJURY COMPENSATION SYSTEM DEMONSTRATION PROJECTS

With due respect to the understanding, knowledge and detailed information that can be derived from well-designed and implemented research projects, the true understanding of the problems, advantages and limitations of the non-fault-based system can only be derived from the operational experience gathered within the "real world". Because of the importance of the issues being dealt with and the many segments of our society being affected, it would be premature to initiate such a major system without the benefits derived from several pilot demonstration projects.

Although the actual designs for such projects have not been developed herein, it is believed that certain settings appear promising, e.g., newly-created Health Maintenance Organizations, government-operated health care institutions such as those within the Veterans Administration and Public Health Service, and military health care facilities. It can be expected that there would be more opportunity for selective and careful experimentation within these locations than would exist in the private sector.

It is proposed that a study effort be initiated, at the earliest possible time, to consider the forms of non-fault-based medical injury compensation systems and the settings within which they would be embedded, along with carefully constructed system designs and evaluation programs.

Appendix A Alternative Concepts of Compensable Medical Injury

The adoption of a definition of compensable medical injury based on the legal principle of strict liability has been recommended. The specific definition was formulated after extended study of alternatives, the highlights of which are reported in this Appendix.

Following Carlson one can describe concepts for compensation of medical injury along a continuum. At one extreme is the current tort-liability system which "rests upon the scrutiny of episodes of care to detect tortious conduct proximately resulting in harm to a patient to whom a duty to provide care feee of harm was owed". The shortcomings of this (present) definition have been discussed in Section 2 of this Report. On the other end of the continuum would be a total social insurance scheme "affording compensation to all those who pass through the health care system and come out at the other end in worse shape than when they went in, leaving aside any relationship between the outcomes of care and a set of expected outcomes for like procedures". Such a scheme the philosophy of which is discussed in Bernstein's study[13] does not appear acceptable in the United States on social, political and economic grounds.

Carlson proposes several middle-ground definitions based on the notion that compensation should be awarded for outcomes of medical intervention that deviate substantially from an expected outcome. Essentially the idea is that for a given medical condition of a patient a distribution of outcomes can be established on the basis of aggregated experience and compensation can be based on some cut-off criterion. In Figure A-1 such a hypothetical distribution is shown. The abscissa scale is the range of possible outcomes, and varies from death to complete recovery. The ordinate denotes the number of cases associated with each outcome. The dotted line represents a hypothetical dividing line which separates compensable outcomes (to the left of the line) and noncompensable outcomes (to the right of the line). The position of this line may be based on the outcome (degree of recovery) or on the relative number of cases contained under the curve to the left of the line. For instance, Carlson recommends that compensation be paid if no more than 33.3% of the interventions on record have resulted in such poor outcomes.

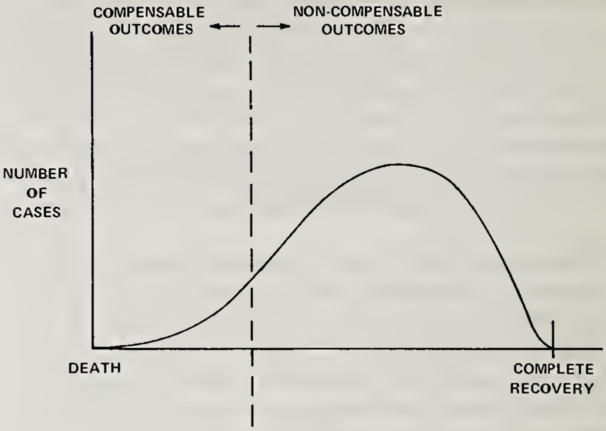

Figure A-1 OUTCOMES DISTRIBUTION

Given that a sufficiently large set of such distribution curves were available now, such a compensability definition would afford the advantage of determining compensability by using published tables and schedules, i.e. with a high degree of objectivity and predictability of application. However, although beginnings at collecting such data have been made and for instance, a very detailed classification scheme for diseases exists[14], the time when sufficient data for even partial application will be available, appears at least 5-10 years away. Some of the difficulties in establishing the necessary data base are (1) the degree of recovery depends not only on the diagnosed disease but also on the state of the patient (age, sex, general state of health, economic conditions, climate, etc.) (2) in many cases patients suffer from more than one disease, a factor which tends to reduce the number of cases that can be plotted one distribution. Some of the difficulties are conceptual: no consistent scale is readily apparent for grading outcomes between complete recovery and death; severity of the disability must be rated separately if it is to be included in determining the amount of compensation. Other parameters, such as the time period between medical intervention and outcome measurement are not explicitly considered. The time parameter should include the notion of undue delay in recovery. (This difficulty may be overcome by applying the outcomes model in time steps, i.e. from first intervention till, say a first diagnosis of the disease, from a first diagnosis till a second diagnosis, etc.)

In sum, the introduction of statistical outcomes models as the basis for determining compensability, while attractive, is premature because the state-of-the-art of medical research does not provide the necessary data base and secondly, because certain conceptual problems have not yet been resolved. However, it appears possible to implement the concept on a subjective basis whereby a panel of medical experts adjudges the "normal" outcome for the particular case and the extent of deviation from the normal. The compensability definition recommended in the body of this Report differs from such an outcome mode by its emphasis on defined injuries.

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[13] "No-Fault Compensation for Personal Injury in New Zealand", *Infra*, pp

[14] International Classification of Diseases (ICDA), Eighth Edition, Public Health Service Publication No. 1693 (Vols. 1 & 2) December 1968.

Two other definitions of compensable injury that were considered and discarded should be mentioned.

The first is one proposed by Boyden:[15]

> Disability [injury] caused by medical attention is compensable, except that which is medically required as part of the management of the patient's condition.
>
> Within the context of medical injury, disability is described as having three forms: physical impairment, disfigurement and "pain and suffering".

The single limitation of this definition, especially from the viewpoint of the health care providers, is the absolute nature of its condition of compensation. What is stated strongly is that the specific medical attention provided gave rise to the disability (injury). To some degree, the acceptance of this definition within a non-fault-based context would present a conceptual contradiction that would be highly unsatisfactory to the health care provider community. The inclusion of pain and suffering makes the definition broader in scope than the one recommended in this study. On the other hand, it does not include all medical injuries covered under tort-liability, such as lack of informed consent. Therefore, this definition was not adopted.

The second definition considered consists of two possible additions to the set of compensable medical injuries defined in Section 3 as ". . . more probably associated in whole or in part with medical intervention rather than the condition for which such intervention occurred . . .".

The first addition is concerned with *permanent total disability*. Utilizing the concept of the New York State Workmen's Compensation Board's definition, a permanent total disability is defined as any medical injury which permanently and totally incapacitates a patient from engaging in his or her previous major role, or which results in the loss of or the complete loss of use of any two major members of the body. Within this definition of a compensable medical injury there is no consideration given to the potential injury causation actions of the health care providers. What would be included in the determination, as to whether or not the injury is compensable, is the expectancy of the outcome—that is, the experiencing of the permanent total disability for the particular diagnosis or input conditions. Further analysis would be required to establish appropriate cut-off points of outcomes related to initial inputs. It is recognized that the decision concerning admissibility must be based on funding considerations and an agreed-upon social compensation philosophy.

The second addition to the definition of compensable medical injury incorporates from the New York State Workmen's Compensation Board the concept of *permanent partial disability*. Within the context of a non-fault-based medical injury compensation system, permanent partial disability would be defined as any medically-induced injury other than a permanent total disability which results in the complete loss or loss of use of any member or part of a member of a body, or any permanent impairment of functions of the body or part thereof; also included are medical injuries resulting in serious disfigurement. As in the case of the above definition (related to permanent total disability) there is no consideration given to the potential injury causation actions of the health provider. However, as before, a determination is required as to whether or not the outcome (that is, the disability) experienced by the patient is expected. As stated within the above discussion of expectancy, further analysis would be required to establish appropriate and acceptable cut-off values and thereby enable the system to classify these disabilities into the compensable/non-compensable categories.

It is felt that addition of the above definitions of permanent total and permanent partial disability to the compensable medical injury definition would, at this time, not be acceptable to health care providers, the public and state legislatures. The proposed definition of compensable medical injury, as described in Section 3 and the Model Law, is drawn in such a way that it encompasses all medical injury categories held compensable under the present tort-liability system, with only such expansion of scope as is necessitated by the strict liability concept. However, the definition is formed in such a manner that its scope can readily be expanded or reduced through modification and interpretation of its terms, such as bodily harm, impairment and disfigurement. An appropriate addition to the definition appears feasible, if at a later time the inclusion of compensability for permanent total and permanent partial disability should become desirable.

Appendix B

Estimate and Analysis of System Characteristic Weights

The comparative evaluation of alternative non-fault-based medical injury compensation modes has been performed by summing a series of weighted scores for each mode. The degree of attainment of the mode relative to 19 system objectives has been scored using an ordinal scale ranging from 1 (poor) to 5 (good). These 19 system objectives are divided into 5 groups; each group constituting a system characteristic: Equitability, Efficiency, Cost, Effectiveness, and Management. The relative importance of these system characteristics (i) is designated by a weight, W_i, which is multiplied by its normalized objective-attainment scores, N_i. These products are summed to yield the Mode Score, ΣW_iN_i. This discussion is concerned with the methods employed for deriving these weights.

Weights (or values) were assigned by 10 evaluators, four from the project staff, two project consultants (one medical and one legal), and 4 Calspan employees who are not associated with the project. The three groups were briefed on the objectives of the Secretary's Commission on Medical Malpractice, the project, the non-fault-based modes under consideration, and the system characteristics and objectives. After this orientation they were asked to assign a weight, ranging from 1 to 9, which represents the importance they attached to each system characteristic. One of the agreed-upon rules was that the weights need not rank the importance of the system characteristics, i.e., the same weight could be assigned to more than one, and in fact to all the system characteristics. Choices of system characteristics weights were made independently by each evaluator, without knowledge of the other evaluators' choices and without discussion among the evaluators.

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[15] See "Medical Injuries Described in Hospital Patient Records", *Supra*, p.

The system characteristics weights are listed in Table B-1. Since the evaluators were not asked to rank the importance of the system characteristics their scores had wide variation and little pattern or regularity was recognized. As was expected, equitability was rated high by each evaluator. The cost characteristic was the only system characteristic which was chosen as most important by some and least important by others. The two most extreme costs weights (W_3), those of evaluators A and C were used for score computation. Two additional weight sets were selected on the basis of a simple correlation analysis.

TABLE B-1
SYSTEM CHARACTERISTICS WEIGHTS

Weight Code	System Characteristic	Evaluator									
		A	B	C	D	E	F	G	H	I	J
W_1	Equitability	9	7	8	9	9	9	8	9	9	8
W_2	Efficiency	5	6	5	4	7	7	7	6	7	4
W_3	Cost	1	8	9	3	8	5	7	5	7	4
W_4	Effectiveness	7	8	7	7	9	9	8	7	9	4
W_5	Management	6	6	5	5	7	7	9	4	6	8

Evaluators:		
	A, B, C, D	Calspan Project Staff
	E, F, G, H	Other Calspan Employees
	I, J	Project Consultants

Correlation trends are shown graphically for three pairs of evaluators in Fig. B-1. On the right side of Fig. B-1 are shown the Pearson Correlation Coefficients which are product moment coefficients (r) pertaining to these evaluation pairs. The zero-correlation graph shows the most divergent trends and the high-correlation graph a more "parallel" trend in weight assignment by the respective observer pairs. Pearson coefficients were computed for each of the 5 pairs of weights of all pairs of evaluators and each evaluator's correlation coefficients were summed, Σr (Fig. B-2). The weights of the evaluator whose choices were most highly and least correlated $(\Sigma r)_{max}$ and $(\Sigma r)_{min}$ were also used for score computation. Finally, though not picked by any of the evaluators, an equal-weight, or unweighted, mode score was also computed.

Figure B-1 CORRELATION TRENDS

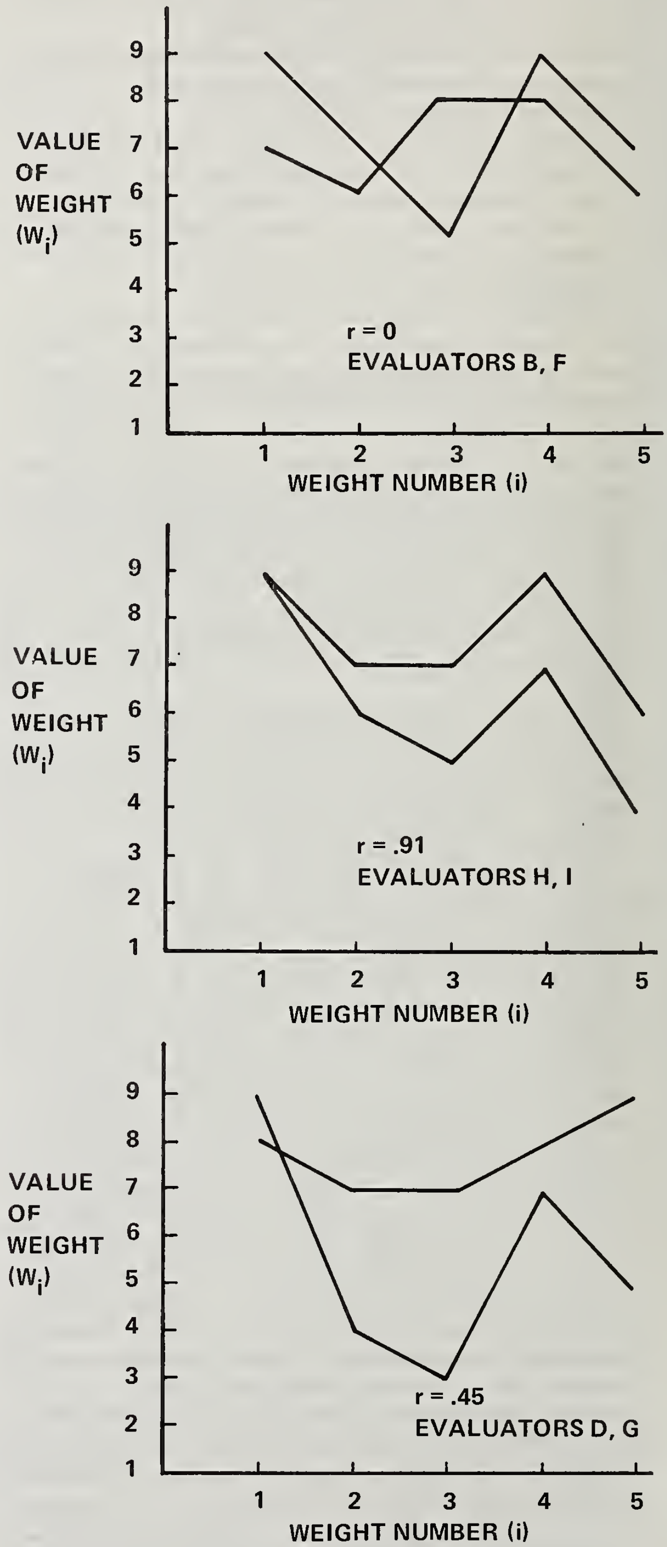

FIGURE B-2
PEARSON CORRELATION COEFFICIENTS (r),
OF SYSTEM CHARACTERISTICS WEIGHTS

Evaluator	A	B	C	D	E	F	G	H	I	J
A										
B	.25									
C	.25	.84								
D	.92	.10	.15							
E	.42	.75	.70	.73						
F	.95	0	.13	.92	.60					
G	.56	.30	.37	.45	0	.43				
H	.67	.26	.38	.83	.78	.75	.12			
I	.58	.56	.48	.79	.93	.76	.09	.91		
J	.58	.46	.15	.53	0	.33	.76	.14	.07	
Σr	5.18	3.52	3.45	5.42	4.91	4.87	3.08	4.84	5.17	3.02
				High						Low

Appendix C

Cost and Funding Considerations of the Tort-Liability and Non-Fault Based Approaches to Medical Injury Compensation

INTRODUCTION

Quantitative comparisons of (1) the cost and funding requirements of the present tort-liability procedures with those of the recommended non-fault-based system and (2) among the non-fault-based modes considered in this Report should be possible when the necessary data have been collected. This Appendix lays the base for such quantitative comparison. The cost components of the liability insurance that is carried by health care providers under the present system is examined and an elementary framework for quantifying the differences between the two compensation concepts and among non-fault-based modes is explored.

It should be noted that the work reported on does not treat the total system cost for either the tort-liability or the recommended system. The approach taken has been to examine the factors affecting the individual cost components associated with the total premium requirements of the insurance carriers so as to anticipate how various aspects of the non-fault-system will change these requirements. Generalized cost and funding models of the tort-liability and non-fault-based systems are provided so as to allow for a preliminary assessment of those operational and administrative characteristics of the non-fault-based system (as described in Section 3 of the Report) which influence the total revenue requirements.

GENERALIZED COST AND FUNDING CONSIDERATION AFFECTING MEDICAL LIABILITY RATES AND FUNDING REQUIREMENTS

Within the framework of the existing tort-liability system for handling negligence suits the health care providers (i.e., physicians, hospitals, etc.) are the parties who carry the insurance coverage and consequently are the basic sources of funding for the costs of the system. In its fundamental form, the insurance premium which a health care provider pays can be thought of as consisting of three basic cost components:

(i) R = the "risk" portion of the insurance premium, i.e., that amount which should equal the expected value of a settlement to a claim leveled against the policy. While relatively few insured parties have claims entered against them, the risk portion is determined on an actuarial basis so that, when averaged over the many insured parties, the total cost of settlements equals the total risk portion collected from the insured.

(ii) A = the administrative component of the insurance premium, i.e., those operating costs incurred by the insuring agent in maintaining this line of insurance.

(iii) E = the earnings or profit component of the insurance premium.

The sum of these three components (expressed on a per-policy basis) constitutes the magnitude, P, of the premium which an individual health care provider will pay; that is:

$$P = R + A + E \tag{1}$$

In establishing premium rates, the insurer normally attempts to estimate the *total* risks anticipated for the particular line of insurance under consideration and the loss ratio which is acceptable to him as an insuring agent (i.e., the ratio of total risk to total premium). Then, employing these two quantities, the total necessary premium required is estimated as

$$P = R \div (L.R.) \qquad (2)$$

where:

P = total estimated premium for this insurance line
R = total estimated risk for this insurance line
$L.R.$ = desired loss ratio

With an estimate of the total premium needed to successfully underwrite this line of insurance the insurer can then determine the premium rate for an individual policy by spreading the total premium over the anticipated number of health care providers, N, to be covered. We have then,

$$P = P \div N \qquad (3)$$

where:

P = individual policy rate
N = total number of insured parties
P = total estimated premiums

While the total estimated premium is determined by employing risk estimates and loss ratios, it can alternatively be considered as consisting of the three basic components of (1) Total risk, R; (ii) Total administrative costs, A; and (iii) Total earnings, E for this insurance line; that is:

$$P = R + A + E \qquad (4)$$

Let us consider expression (4) from a somewhat different point of view. The right-hand side of the expression, i.e., R + A + E can be viewed as the "cost" of the current system and the left-hand side, P, as the "funding" of the current system. The funding mechanism is essentially that of spreading the total "cost" among the number of insured health care providers (say, N) uniformly at the premium rate P, so that $P = N \cdot P$. The cost mechanism can be expressed as:

$$N\overline{C} + A + E$$

where:

N = average number of claims settled
$\overline{C}$ = average size of a settlement

and A and E are as defined previously. We thus have (4) rewritten as

$$\underbrace{N \cdot P}_{\text{total funding}} = \underbrace{N{:}C + A + E}_{\text{total cost}} \qquad (5)$$

It is helpful to discuss, in particular, the major components which make up two of the cost elements in (5) above. Specifically, $\overline{C}$ and A are considered for it is primarily through a modification of the nature and magnitude of these components that the proposed non-fault-based medical injury compensation system is seen to offer hope of being "cost-effective".

The average settlement, $\overline{C}$, can be viewed as consisting of three main components—(1) $\overline{C}_1$—the average level of special damages (e.g., medical bills, salary loss, etc.) awarded, (ii) $\overline{C}_2$—the average level of general damages awarded (e.g., pain and suffering) and (iii) $\overline{C}_3$—the average level of fees for legal representation. Thus, we have

$$\overline{C} = \overline{C}_1 + \overline{C}_2 + \overline{C}_3 \qquad (6)$$

The administrative costs are considered to be segmented into two major categories: (1) those total administrative costs associated with non-meritorious claims which are either dropped or otherwise result in no settlement. These costs are expressed as $N_1\overline{A}_1$ where N_1 is the number of non-meritorious claims and $\overline{A}_1$ is the average (unit) administrative cost to handle such a claim; (2) those total administrative costs associated with meritorious claims (N of them) which result in a settlement or award at an average (unit) administrative cost of $\overline{A}_2$, thus yielding a total administrative cost of $N\overline{A}_2$. We thus obtain

$$A = N_1A_1 + NA_2 \qquad (7)$$

Upon substituting (6) and (7) into (5) we obtain

$$\underbrace{N \cdot P}_{\text{total funding}} = \underbrace{N(\overline{C}_1 + \overline{C}_2 + \overline{C}_3) + (N_1\overline{A}_1 + N\overline{A}_2) + E}_{\text{total cost}} \qquad (8)$$

This expression restates the "cost" of the current system in terms of components which can be related to corresponding components of the recommended non-fault-based compensation system.

IMPACT OF RECOMMENDED NON-FAULT-BASED SYSTEM ON INSURANCE COSTS AND FUNDING

In the context of the proposed non-fault-based medical compensation system let us consider the components of expression (8). The total risk portion will very likely increase in the following manner. The total number of claims and settlements will very likely increase due to both the broadened coverage under the definition of compensable injury and the activities of the claim review mechanism. Let us denote the number of settlements (under the proposed system) as N'. It is difficult to estimate the average magnitude of special damages, $\overline{C}_1'$, under the proposed scheme. However by introducing simplified proceedings to reach a decision regarding a claim, the average fees for legal representation, $\overline{C}_3$ should be reduced significantly. Further, within the proposed system there is no provision for general damages (i.e.—C_2) recovery. We see then that the total risk under the proposed system is:

$$N'(\overline{C}_1' + \overline{C}_3'). \qquad (9)$$

The Medical Injury Compensation Commission, through its screening activities, would minimize the need for insurers to devote any significant administrative effort on non-meritorious claims, and consequently the bulk of the administrative component of the insurers costs would be:

$$N'\overline{A_2'} \qquad (10)$$

where $\overline{A}_2'$ is the average (unit) administrative cost per meritorious claim, and N' as defined previously.

A final component of the "cost" under the recommended system is the cost of the Medical Injury Compensation Commission operation. Let us relate this to the total average number of claims to be considered i.e., $N' + N_1'$, and the average cost, $\overline{A}_1'$, to administrate claims handled (both the N' meritorious and N_1' non-meritorious claims to be encountered). The total operating cost of the Commission is then

$$(N' + N_1')\overline{A}' \qquad (11)$$

Combining the anticipated costs under the recommended system, we obtain:

$$\underbrace{N'(\overline{C_1'} + \overline{C_3'}) + N'\overline{A_2'} + E}_{\text{total cost component associated with insurers}} + \underbrace{(N_1' + N')\overline{A'}}_{\text{total cost component associated with Commission}} \qquad (12)$$

With respect to the funding aspect of the proposed system, a broadened base of funding sources is seen (in contrast to the current fault-based system). This funding would derive from three sources:

(i) The currently insured health care providers (numbering N_1' insured parties); this group contributing at the actuarially based rates P_1.

(ii) The population of health care recipients currently covered by some form of health insurance policy. This group, numbering N_2', would contribute at the actuarially based rate P_2.

(iii) The population of taxpayers (numbering N_3) in the state concerned, contributing at a rate P_3.

The total funding revenues are thus seen to be

$$N_1 P_1 + N_2' P_2 + N_3' P_3 \qquad (13)$$

It should be noted here that a given individual can conceivably fall into more than one of the above funding categories. For example a citizen carrying health insurance coverage would be contributing to the funding at a rate of $P_2 + P_3$ since through his medical coverage he contributes at the rate P_2 and through the general tax levy he contributes at the rate P_3. Expressions (12) and (13) constitute the "cost" and "funding" balance expression for the recommended compensation system in a manner analogous to expression (8) for the currently existing fault based system.

$$\underbrace{N_1' P_1 + N_2' P_2 + N_3' P_3}_{\text{total funding}} = \underbrace{N'(\overline{C}_1' + \overline{C}_3') + N' A_2' + E' + (N_1' + N')\overline{A}'}_{\text{total costs}} \qquad (14)$$

THE MEDICAL MALPRACTICE INSURANCE MARKET

Mark Kendall
John Haldi

Summary

During the decade 1960 to 1970, the size of the medical malpractice insurance market, as measured by premium volume, has increased over five-fold, from approximately 65 million in 1960 to over 330 million in 1970. The increase is distributed among dentists whose premium payments more than doubled; physicians increased six-fold; surgeons, ten-fold; and hospitals, three-fold. The increase in premium volume reflects the increase in both the frequency and severity of malpractice incidents. Today virtually no medical professional can afford to practice without some form of malpractice insurance and most find themselves requiring increasingly higher limits in order to be adequately protected.

The cost of a constant level of medical malpractice insurance coverage increased seven-fold for physicians, ten-fold for surgeons, and fivefold for hospitals between 1960 and 1972. The areas which whowed the greatest increase in the cost of constant coverage over these years were California and New York City which increased over 25 percent faster than the nation.

Group insurance plans sponsored by state hospital associations or medical societies have grown substantially during the past five to ten years. Growth of these plans will likely continue, and in the process consolidate the market, in terms of the number of active carriers, still further. Within the foreseeable future, it is possible that group plans may so totally dominate the market that insurance carriers will cease selling policies to individual hospitals or practitioners. Such a monopoly monopsony situation would be socially unacceptable, and it is desirable to retain the viability of the individual market.

Widespread growth of group plans will cause normal market functions (such as groups switching carriers or carriers dropping a group) to be larger in scope and hence require longer for orderly functioning. Hospital associations, medical societies, and insurance carriers should undertake to guarantee six months notice of intent to cancel or nonrenew.

The malpractice insurance market is increasingly specialized, and requires increasing knowledge, information, and sophistication in order for a carrier to operate with a reasonable probability of earning a profit. In order to maintain and promote viable competition, a uniform statistical reporting plan should be established, all carriers required to report all their malpractice data to a single reporting agency, and all reported data be made available to state insurance regulators, insurance companies, auditors, and other interested parties.

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I. Introduction

In recent years, it has been widely alleged that the malpractice insurance market is neither stable nor viable. This market clearly has experienced some fundamental problems. For example, premiums have escalated steeply and the market has appeared highly volatile and limited, with carriers intermittently leaving or entering the field.

The stability and durability of the malpractice insurance market could have widespread impact on health care practices and delivery since practitioners might hesitate to try new methods or even practice their specialty without insurance protection. One consequence of this possibility has been the suggestion, embodied in proposed legislation, that the federal government create a facility for reinsuring malpractice insurance policies. Thus, it is important to develop objective standards for judging the stability and durability of the malpractice insurance market. The many questions which need to be answered include: Does competition exist in the medical malpractice insurance market? What types of carriers are still in the market? What is the rationale for current rate-making practices? What will be the impact of widespread group-sponsored plans?

The medical malpractice insurance market is directly affected by and reflects events in a number of closely related areas. Changing legal standards, for example, can and have had substantial impact on malpractice insurance. The same is true of changing health care standards and practices. Readers should recognize, however, that this is but one of several studies undertaken by the Secretary's Commission on Medical Malpractice. The existence of these other studies, which explore related areas in detail, plus limited time constraints, kept the scope and focus of this study exclusively on the malpractice insurance industry. One of the studies is a survey of closed malpractice claims, undertaken in cooperation with several interested insurance carriers. While information developed from the closed claims survey is obviously pertinent to a study of the malpractice insurance industry, time did not permit it to be included here.

A. PURPOSE

This study had three major purposes. The first is to assemble and present comprehensive and as systematic a data base as possible within the time constraints which were imposed. Prior to this study only scattered and incomplete quantitative data were available to support any conclusions about the viability or stability of the malpractice insurance market. The second purpose is to sample and conduct an indepth study of the rapidly evolving group insurance plans. This includes an assessment of both the plans themselves and the implications which their continued growth holds for the entire malpractice insurance market. The third purpose is to analyze all available data and information towards determining the viability of the malpractice insurance market, including the likelihood that malpractice insurance will continue to be available in a competitive market.

B. OVERVIEW

Because of the paucity of published statistics in this area, almost all data gathering, information and fact-finding for this study were by means of field surveys and mail questionnaires. Most of the survey effort was directed at insurance carriers, with all remaining surveys being directed at hospital and practitioner group plans. This study specifically excluded any systematic survey of intermediaries (insurance salesmen, agents or brokers) or individual purchasers (e.g., hospitals or practitioners). The methodology, interview guides and questionnaire forms which were used for this study are discussed in more detail in Section II and the Appendix, B.

Section III presents the data and information obtained from the field surveys and questionnaires, including an overview of group malpractice insurance plans (details of the plans which were surveyed will be found in the appendix). This chapter, together with the Closed Claim Survey, constitutes the major source of information and data on the malpractice insurance industry. The chief purpose of Section III is to describe, in as quantitative and analytic way as possible, the extent and nature of the malpractice insurance market.

Section IV contains a discussion of the most salient features of the industry. Early in this study it became apparent that this market is best analyzed in terms of two subdivisions: the group market and the market for individual policies (i.e., policies sold to individual hospitals or practioners without any form of group sponsorship or endorsement). This distinction is important because many generalizations which apply to one market do not apply to the other market. Discussions which fail to make this distinction are frequently confused. It also became apparent rather early that a few high-risk specialties—notable anesthesiologists, neurosurgeons and orthopedic surgeons—constitute good indicators both of where the entire market is going and where the most severe problems will arise in the future. These too are discussed in Section IV.

Section V contains findings, conclusions and recommendations relating to two important areas: continued availability of malpractice insurance from competitive sources and a centralized statistical or data source for malpractice insurance. Due to the thinness, special risks and requirements of this market, it appears that in the future these two will be closely related. The best hope of preserving viable competition in this market lies in the direction of substantially improving the quality and availability of essential loss data.

Section VI contains a number of recommendations for further research which should overcome certain limitations imposed on this study due to the tight time constraints. In addition, and perhaps more important, continued study of this area should help attract strong, sophisticated insurance carriers to enter or remain in the field, thus enhancing competition and the working of the market.

II. Method

The research was divided into three segments:

- Case studies of group[1] medical malpractice insurance programs;
- A statistical description of the medical malpractice insurance market; and
- An analysis of the market's historical behavior and future course.

The research methodology employed during the first two segments was basically a survey of a sample from the appropriate universe followed by a tabulation of the results. The final segment relied on the results of the first two.

A. CASE STUDIES OF GROUP MEDICAL MALPRACTICE INSURANCE PROGRAMS

An interview guide was developed for hospital and physician group medical malpractice insurance programs. The cases studies were limited to hospitals and physicians as they are the most obvious problem areas for medical malpractice. Also, hospitals and physicians have many localized (county and state level) programs whereas the dentists, osteopaths, and allied health care personnel generally rely on national plans. Thus, limiting the studies to hospitals and practitioners offered a larger payoff in terms of developing general observations and applying the results to a variety of programs.

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[1] There are no "true" group malpractice insurance programs. The exact meaning of the term "group" is discussed in Section III, E.

The guide was targeted at the consumer—hospital associations and medical societies. Although brokers, defense counsel, and some insurance company personnel were interviewed, the emphasis of the case studies was on the consumer. This emphasis obviously lends a consumer bias to the studies. However, as the rest of the study approached the medical malpractice insurance market from the production side, the bias is more than tolerable.

Another shortcoming of the interview approach was the necessary acceptance as fact of what the interviewee said. There was little opportunity to check the interviewee's responses within the framework of the case studies and time available. However, each case study has been analyzed for consistency with what was found through the survey of insurers.

A universe of group medical malpractice insurance programs was identified through the information available at the Commission and by calling selected national hospital and medical associations. The number of case studies was limited to nine by the time constraints of the study. Six of these case studies were designated for physicians and three for hospitals. More physician programs were included as they are more numerous and, *a priori*, it was thought that there was more variability among physician programs.

The physician programs selected were:

- American College of Obstetricians
- Los Angeles County Medical Society
- Minnesota State Medical Association
- Medical Society of the State of New York
- Medical Society of Virginia
- Florida Medical Association

The selection was based on geography (one state and one county plan), the existence (or non-existence) of peer review, age, size, carrier, and recent developments (such as switching carriers).[2]

The hospital programs were:

- California Hospital Association
- Hospital Association of Pennsylvania
- Texas Hospital Association

The selection was based on the use of an arbitration system, whether the plan was endorsed or sponsored, size and carrier.

B. DESCRIPTION OF THE MEDICAL MALPRACTICE INSURANCE MARKET

The description of the medical malpractice insurance market was based on a personal interview of 21 insurers and two reinsurers and mail survey of 47 other malpractice insurers.

The interview guide was divided into eight segments. The first two were devoted to general policy questions concerning malpractice insurance and specific data requests for the policy years 1960-1970. The remaining six segments contained specific questions on:

- selling and marketing
- underwriting
- actuarial practices
- claims adjusting
- loss prevention, and
- reinsurance

The guide was modified for the two reinsurers. The mail questionnaire made specific data requests similar to those in the interview guide.

The universe of malpractice insurers was obtained from three sources: those insurance carriers identified by the Malpractice Commission as writers of malpractice insurance; all insurance carriers which report malpractice loss premium information to the Insurance Services Organization; and any insurance carrier identified with this area from a survey of the malpractice literature. The Commission's list was revealed to contain all known major malpractice carriers as well as some minor ones. ISO is the principal statistical reporting organization and rating bureau for malpractice insurance from which data are actually available. Most minor carriers report to ISO in order to use its rates. Thus, the combination of the Commission's and the ISO's lists plus those firms identified in the literature survey results in a good approximation of the universe of malpractice insurers.

The 21 primary carriers selected for a personal interview included the top ten insurers (as determined by a Commission study) in terms of 1970 claims received or premiums written (or both). Also included were any insurers which had an associated actuary who specialized in malpractice.[3] These three criteria determined twelve firms for inclusion. The remaining nine firms were selected on the basis of their proximity to the first twelve. The reinsurers were selected from those mentioned in the interviews with carriers.

C. ANALYSIS OF THE MEDICAL MALPRACTICE INSURANCE MARKET

The analysis was based primarily on the results of the interviews, the case studies of group plans, the testimony before the Commission, discussions of the Commission's insurance subcommittee, and other sources such as ISO. Tabulations were prepared for those areas subject to such manipulations. The responses to the discussion questions were brought together during staff meetings and the implications discussed. The results of the tabulations and discussions are summarized in Sections IV, V, and VI.

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[2] A complete description of the universe and selection process is given in Appendix B.

[3] A complete description of the universe and sample selection is given in Appendix C.

III. Results

Results of the surveys discussed in the preceding section are presented here. The purpose of this section is to describe the medical malpractice insurance market as quantitatively and analytically as possible within the overall time and budget constraints.

The market for medical malpractice insurance is composed of

- Those insurance carriers, who sell or underwrite malpractice insurance (sellers)
- Those hospitals or practioners who buy malpractice insurance (consumers)
- Those insurance salesmen, agents or brokers who sell malpractice insurance (intermediaries)

Patients who may have suffered from negligence and have a cause of action against a hospital or practitioner are, from the viewpoint of economic analysis, not considered part of the malpractice insurance market, regardless of whether their claims are in fact paid. Thus, to keep the record straight, it should be pointed out that a companion research project of the Secretary's Commission on Medical Malpractice dealt with a survey of patients, but was referred to frequently as a survey of "consumers". It is more correct to state that patients are consumers of health care services, and although they may be victims of malpractice, they are not consumers of malpractice insurance. The term *consumers* in this study will refer exclusively to purchasers of insurance, not patients.

Using this clarification or distinction between patients and consumers, it should also be pointed out that surveys in this study were limited to insurance carriers and a few group plans. No systematic survey of consumers or intermediaries was undertaken, and both the description and analysis suffer from this omission. Description of the market is based chiefly on information derived from those sellers who were interviewed, and information about consumers, agents or brokers is based on fragmentary or hearsay evidence picked up from a variety of sources during this study. Findings and conclusions related to these aspects of the market are therefore somewhat tenuous in comparison to findings which relate to carriers. Some suggestions for improving the obvious weakness of this study will be found in Section VI, Recommendations for Further Research.

Still another caveat pertains to the Closed Claims Study, which was another project undertaken by the Commission. The Closed Claim Survey undoubtedly contains much information which would have been useful to this analysis, but unfortunately the timing of the two studies did not permit inclusion of the closed claims survey data. It is hoped that this and the other studies will provide researchers with a good basis for developing a more complete analysis of the medical malpractice insurance market.

An attempt was made to make each sub-section of this section somewhat self-contained. However the length or brevity of various sections reflect the short twelve week project horizon, and in consequence some of the sections may appear longer or shorter than seems appropriate to the problem(s) explored. In general, this section reflects a bias towards including most of the available information, with relatively little screening for relevance.

A. SCOPE OF THE MARKET

During the past five years, the frequency and severity of medical malpractice suits has been increasing at a substantial rate. As a result, the potential market for professional liability or medical malpractice insurance has expanded both in terms of demand for higher coverage by some medical specialties and institutions as well as demand for coverage by an increasing number of specialities and institutions. Thus, the present market for medical malpractice insurance can be divided into two broad categories: institutions and charitable associations; and health care professionals and allied health care personnel.

Institutions and charitable associations

Until recently, many states protected hospitals, charitable associations, and other medical care institutions from litigation by the doctrine of charitable immunity. However, this doctrine has been overturned, and at the present time the only states affording any degree of protection are North and South Carolina and Virginia. Excepting the charitable institutions in these states, most of the hospitals, other medical care institutions, and charitable associations are potential purchasers of malpractice insurance. These institutions can be classified as follows:

a. clinics, dispensaries, and infirmaries treating outpatients
  – osteopathic clinics
  – drugless healing institutions run by naturopaths or Christian Scientists
b. convalescent or nursing homes
  – for the aged
  – for other invalids
c. hospitals
d. veterinary hospitals
e. mental psychopathic institutions
  – for mental illness
  – for drug and narcotic addict treatment
  – for treatment of alcoholics
f. sanitariums or health institutions—not hospitals or mental psychopathic institutions
g. charitable associations such as the Easter Seal Society and the International Rehabilitation Society

Table III-1 indicates the level and trends of the size of the overall institutional market for malpractice insurance, and Table III-2 presents a detailed breakdown of the number of hospitals by type of hospital as defined by length of stay, major type of service, and financial structure. The overall percentage changes in hospital facilities, personnel, and usage between 1960 and 1966, and 1966 and 1971 are derived in Table III-3. While the actual number of hospitals in the country increased only four percent between 1960 and 1966 and decreased between 1966 and 1971, the number of outpatients more than doubled. Thus, while the physical market for institutional malpractice insurance, i.e., the number of hospitals, did not increase significantly during this period the exposure of the institutional market had increased. The significant increase in the number of persons employed by hospitals, 62 percent over this 11 year period, has likewise increased the hospitals' exposure.

Health care professionals and allied health care personnel

The rise in frequency and severity of malpractice claims over the past five years have made virtually every person associated with the health field a potential victim of litigation. While professional medical specialists in vulnerable fields; e.g., anesthesiologists, have been aware of their need for professional liability insurance for many years (indeed many would probably refuse to practice without it), more persons connected with almost every conceivable aspect of medicine are coming to regard medical malpractice insurance as a necessity.

In this perspective, the potential market for professional liability or medical malpractice insurance would extend to all of the following health care professionals and allied health care personnel.

a. health care professionals
    1. physicians
    2. surgeons
    3. dentists
    4. osteopaths
    5. veterinarians
    6. medical students
b. allied health care personnel
    1. chiropractors
    2. dental hygienists
    3. dieticians
    4. inhalation therapists
    5. medical assistants[4]
    6. medical technologists
    7. midwives
    8. mohelim[5]
    9. naturopaths
    10. nurses
    11. occupational therapists
    12. opticians
    13. optometrists
    14. optometrists
    15. physician therapists
    16. physician assistants
    17. podiatrists
    18. X-ray technologists

Table III-4 shows the number of physicians and surgeons in the United States by specialty for years 1963 through 1970, and Table III-5 summarizes the percentage changes for these categories over the eight year period. It is interesting to note that while the total number of physicians has increased by 21 percent, the number of physicians in general practice has decreased by 22 percent with medical specialties increasing 36 percent, surgical specialties

Table III-1. U.S. HOSPITALS 1960-1971: GROWTH TRENDS IN FACILITIES PERSONNEL AND USAGE

Year	Number of Hospitals	Number of Beds (000)	Personnel (000)	Occupancy (%)	Outpatients Hospitals Reporting	Outpatients Total Visits (000)
1960	6,876	1,658	1,598	84.6%		
1961	6,923	1,670	1,696	83.4		
1962	7,028	1,689	1,763	83.3	5,291	99,382
1963	7,138	1,702	1,840	84.0	5,845	118,238
1964	7,127	1,696	1,887	83.8	5,624	125,123
1965	7,123	1,704	1,952	82.3	5,574	125,793
1966	7,160	1,679	2,106	83.3	5,920	142,201
1967	7,172	1,671	2,203	82.6	6,121	148,229
1968	7,137	1,663	2,309	82.9	6,054	156,139
1969	7,144	1,650	2,426	81.6	6,041	163,248
1970	7,123	1,616	2,537	80.3	6,079	181,370
1971	7,097	1,556	2,589	79.5	6,204	199,725

Source: American Hospital Association, *Hospital Statistics 1971,* "Table 1—Trends in Utilization Personnel and Finances for Selected Years 1946-71."

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[4] Used here as any otherwise unspecified person working for a physician in his office, e.g., receptionist, laboratory aide.

[5] Persons who perform ritual circumcisions.

Table III-2. NUMBER OF HOSPITALS BY TYPE, 1960-1971

Type of Hospital	Number of Hospitals 1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
Federal	435	437	447	446	441	443	425	416	416	415	408	407
Nonfederal, Psychiatric[1]	488	483	491	499	487	483	476	470	505	509	519	407
Nonfederal, Tuberculosis	238	222	203	186	187	178	156	105	116	107	101	94
Nonfederal Long-term[2] General and Other Special	308	321	323	323	300	283	291	331	280	260	236	218
Nonfederal Short-term[3] General and Other Special Community (These data are totals of the data in the following three classifications)	5,407	5,460	5,564	5,684	5,712	5,736	5,812	5,850	5,820	5,853	5,859	5,865
Nongovernmental, not for profit, short-term[3] General and Other Special[4]	3,291	3,305	3,346	3,394	3,402	3,426	3,440	3,461	3,430	3,428	3,386	3,363
For Profit, Short-term, General and Other Special	856	848	860	896	870	857	852	821	769	759	769	750
State and Local Governmental Short-term General and Other Special	1,260	1,307	1,358	1,394	1,440	1,453	1,520	1,568	1,621	1,666	1,704	1,752

[1] Includes the following categories: psychiatric, epilepsy, mental retardation, alcholism and/or addictive diseases.

[2] Over 50% of all patients admitted have a stay of 30 days or more.

[3] Over 50% of all patients admitted have a stay of less than 30 days.

[4] Other special includes: maternity; eye, ear, nose and throat; children's; orthopedics; chronic, all other.

Source: American Hospital Association, *Hospital Statistics 1971*, Table 1—"Trends in Utilization Personnel and Finances for Selected Years 1946-1971."

Table III-2. NUMBER OF HOSPITALS BY TYPE, 1960-1971

Type of Hospital	Number of Beds (000)											
	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
Federal	177	178	178	176	175	174	173	175	175	170	161	148
Nonfederal, Psychiatric[1]	722	715	717	715	691	685	639	609	594	570	527	148
Nonfederal, Tuberculosis	52	49	45	39	40	37	31	18	22	20	30	18
Nonfederal Long-term[2] General and Other Special	67	71	73	74	69	66	67	80	67	63	60	54
Nonfederal Short-term[3] General and Other Special Community (These data are totals of the data in the following three classifications)	639	659	677	698	721	741	768	788	806	826	848	967
Nongovernmental, not for profit, short-term[3] General and Other Special[4]	446	458	472	486	499	515	533	550	566	579	592	604
For Profit, Short-term, General and Other Special	37	38	40	44	46	47	48	47	48	48	53	54
State and Local Governmental Short-term General and Other Special	156	162	165	168	176	179	188	191	192	198	204	209

[1] Includes the following categories: psychiatric, epilepsy, mental retardation, alcoholism and/or addictive diseases.

[2] Over 50% of all patients admitted have a stay of 30 days or more.

[3] Over 50% of all patients admitted have a stay of less than 30 days.

[4] Other special includes: maternity; eye, ear, nose and throat; children's; orthopedics; chronic, all other.

Source: American Hospital Association, *Hospital Statistics 1971*, Table 1—"Trends in Utilization Personnel and Finances for Selected Years 1946-1971."

Table III-2. NUMBER OF HOSPITALS BY TYPE, 1960-1971

Type of Hospital					Personnel (000)							
	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
Federal	186	202	207	206	193	199	206	214	210	213	216	225
Nonfederal, Psychiatric[1]	238	248	251	261	264	274	274	277	292	303	305	225
Nonfederal, Tuberculosis	39	37	34	29	30	29	24	15	19	18	18	16
Nonfederal Long-term[2] General and Other Special	55	60	64	67	67	65	69	78	72	68	69	63
Nonfederal Short-term[3] General and Other Special Community (These data are totals of the data in the following three classifications)	1,080	1,149	1,207	1,277	1,333	1,386	1,532	1,619	1,717	1,824	1,929	1,999
Nongovernmental, not for profit, short-term[3] General and Other Special[4]	792	835	875	921	962	1,011	1,104	1,175	1,251	1,330	1,387	1,438
For Profit, Short-term, General and Other Special	48	51	57	64	67	70	77	81	84	88	97	100
State and Local Governmental Short-term General and other Special	241	263	276	291	304	306	352	363	382	407	444	461

[1] Includes the following categories: psychiatric, epilepsy, mental retardation, alcoholism and/or addictive diseases.

[2] Over 50% of all patients admitted have a stay of 30 days or more.

[3] Over 50% of all patients admitted have a stay of less than 30 days.

[4] Other special includes: maternity; eye, ear, nose and throat; children's; orthopedics; chronic, all other.

Source: American Hospital Association, *Hospital Statistics 1971,* Table 1—"Trends in Utilization Personnel and Finances for Selected Years 1946-1971."

Table III-2. NUMBER OF HOSPITALS BY TYPE, 1960-1971

Type of Hospital	Occupancy (%)											
	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
Federal	87.2%	86.4%	86.8%	86.2%	86.4%	86.1%	87.2%	85.0%	83.7%	82.7%	79.6%	83.2%
Nonfederal, Psychiatric[1]	93.1	91.6	90.4	91.9	91.4	88.6	91.0	88.6	89.6	85.9	83.8	83.2
Nonfederal, Tuberculosis	75.4	73.6	73.4	73.0	71.8	70.0	68.2	66.4	65.1	64.7	61.8	60.7
Nonfederal Long-term[2] General and Other Special	86.9	84.8	84.6	84.5	85.8	85.3	84.9	84.1	82.6	82.5	82.0	83.4
Nonfederal Short-term[3] General and Other Special Community (These data are totals of the data in the following three classifications)	74.7	74.3	75.1	76.0	76.3	76.0	76.5	77.6	78.2	78.8	78.0	76.7
Nongovernmental, not for profit, short-term[3] General and Other Special[4]	76.6	76.1	76.8	77.7	78.1	77.8	78.5	79.7	80.0	80.8	80.1	79.0
For Profit, Short-term, General and Other Special	65.4	65.4	67.3	68.0	68.3	68.6	69.0	72.7	73.9	74.6	72.2	71.0
State and Local Governmental Short-term General and Other Special	71.6	71.5	72.3	73.0	73.3	72.8	72.8	72.8	73.9	73.9	73.2	71.6

[1] Includes the following categories: psychiatric, epilepsy, mental retardation, alcoholism and/or addictive diseases.

[2] Over 50% of all patients admitted have a stay of 30 days or more.

[3] Over 50% of all patients admitted have a stay of less than 30 days.

[4] Other special includes: maternity; eye, ear, nose and throat; children's; orthopedics; chronic, all other.

Source: American Hospital Association, *Hospital Statistics 1971*, Table 1—"Trends in Utilization Personnel and Finances for Selected Years 1946-1971."

Table III-2. NUMBER OF HOSPITALS BY TYPE, 1960-1971

Type of Hospital	Outpatients, Total Visits (000) 1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
Federal	-	-	25,968	29,473	30,620	30,393	31,886	34,819	38,426	38,850	42,913	46,504
Nonfederal, Psychiatric[1]	-	-	892	1,162	1,120	1,003	1,607	1,690	1,655	2,040	2,988	46,504
Nonfederal, Tuberculosis	-	-	568	632	680	489	595	462	567	514	784	790
Nonfederal Long-term[2] General and Other Special	-	-	1,227	1,207	1,274	1,277	1,608	1,272	1,394	1,014	1,389	1,020
Nonfederal Short-term[3] General and Other Special Community (These data are totals of the data in the following three classifications)	-	-	70,727	85,764	91,430	92,631	106,524	109,987	114,097	120,831	133,545	148,423
Nongovernmental, not for profit, short-term[3] General and Other Special[4]	-	-	45,921	55,142	59,331	59,223	69,336	73,173	76,428	82,756	90,992	103,016
For Profit, Short-term, General and Other Special	-	-	3,084	3,696	3,801	3,437	4,339	4,020	4,055	3,859	4,698	4,858
State and Local Governmental Short-term General and Other Special	-	-	21,722	26,926	28,297	29,962	32,850	32,794	33,614	34,216	37,854	40,550

[1] Includes the following categories: psychiatric, epilepsy, mental retardation, alcholism and/or addictive diseases.

[2] Over 50% of all patients admitted have a stay of 30 days or more.

[3] Over 50% of all patients admitted have a stay of less than 30 days.

[4] Other special includes: maternity; eye, ear, nose and throat; children's; orthopedics; chronic, all other

Source: American Hospital Association, *Hospital Statistics 1971*, Table 1—"Trends in Utilization Personnel and Finances for Selected Years 1946-1971."

TABLE III-3.

PERCENTAGE CHANGES
IN U.S. HOSPITAL FACILITIES,
PERSONNEL AND USAGE BETWEEN:
1960 and 1966, 1966 and 1971

Growth Indices	Percentage Change 1960-1966	Percentage Change 1966-1970
Facilities		
Number of Hospitals	+ 4%	-- 1%
Number of Beds	+ 1	-- 7
Personnel	+32	+23
Usage		
Occupancy	-- 2	-- 5
Outpatients		
Hospitals Reporting	--	+ 5
Total Visits	--	+40

Source: Table III-1

22 percent, and other specialties 47 percent. To the extent that increased medical malpractice litigation has been related to the decline of the "friendly" family physician and the emergence of the busy and impersonal specialists, the total exposure of the practitioner market has grown markedly. Although dentists have not experienced the severe malpractice claims increase that physicians, surgeons, and hospitals have, most dentists do require medical malpractice insurance. Their number, 112,879 in 1970, gives in indication of the potential size of the market.

B. FEATURES OF MEDICAL MALPRACTICE POLICIES

Professional liability policies are normally written with a given dollar limit on each occurrence and an aggregate limit on all occurrences for the insured for the policy year. These limits start as low as $5,000 per occurrence and $15,000 aggregate ($5/15,000) to $15 million depending upon the nature of the risk and the ability of the carrier to provide increased limits. Two of the carriers surveyed will not write a policy for less than $100/300,000 and require even higher basic limits for certain specialties.

Hospital policies

Liability insurance for hospitals covers three primary areas: professional (or malpractice) liability; general liability (such as premises); and workmen's compensation and employees liability.

Comprehensive general liability and malpractice liability protection are generally written in a single policy or contract. Coverage usually includes the officers, administrators, members of the Board of Trustees, and directors or governors of the hospital. The general liability coverage applies to employees and sometimes to student or volunteer workers. Professional liability covers the professional staff of the hospital and many include technical and support personnel as well.

Hospitals which are written individually are usually rated upon their own experience. In some group plans, the experience of all hospitals participating in the program is pooled for underwriting purposes. It was interesting to note that a large number of hospital policies are written for the same amounts as individual physicians usually buy. If coverage of 100/300 is adequate for an individual physician, then there is a question as to whether these same limits are adequate for a hospital with a potentially higher exposure. The limit of $100,000 on each occurrence may be reasonable for a hospital. However, if an aggregate limit of $300,000 is appropriate for practitioners, then $300,000 for hospitals seems out of proportion to the potential risk.

Practitioner policies

Policies usually are written for one-year periods but may be written for three to five years. In those policies which are written for more than one year, there is usually a provision for rate increases or rebates based upon experience.

The majority of the carriers include premises liability in their basis policy. Some carriers offer premises liability as a rider or extension of the basic policy at an additional premium. Only two of the policies examined did not offer premises liability.

Provisions for covering a partnership, corporation, or professional association may be made by amending an individual policy or by issuing a separate policy. Policies usually include reimbursement for the insured when he must appear in court; however, one carrier requires that this coverage be specifically added to the policy at an additional premium.

Employees of the insured are covered in the policy while acting within the scope of thei duties. A professional such as a resident or other physician, or a dentist must be specified and a premium assessed in order to have coverage. Coverage for other employees such as nurses or technicians may be limited to cases in which they are included in a suit with the insured. At least one carrier will defend any employee acting within the scope of his duties.

Excess limits

Most policies provide coverage up to limits of $100/300,000. If additional coverage is needed or desired there are several ways of writing it. The larger companies have the ability to increase the limits up to 5 or 10 million dollars or possibly even more.

Coverage may be extended simply by writing a larger policy. However, the most common practice is to write excess coverage in an umbrella policy that covers professional, personal, and premises liability. Umbrella policies have the advantage of covering several kinds of risks in one package, usually at a lower premium than individual policies.

Table III-4. NUMBER OF FEDERAL AND NONFEDERAL PHYSICIANS IN UNITED STATES AND POSSESSIONS BY SPECIALTY 1963-1970[1]

Specialty	Year 1970	1969	1968	1967	1966	1965	1964	1963
Total Physicians	334,028	324,942	317,032	308,630	300,375	292,088	284,224	276,475
General Practice	57,948	58,919	61,578	68,920	70,223	71,366	72,375	73,489
Medical Specialties	77,214	71,886	70,944	68,927	65,591	62,791	59,712	56,593
Allergy	1,719	1,706	1,661	962	944	910	870	835
Cardiovascular Diseases	6,476	5,970	5,602	2,263	2,047	1,901	1,820	1,732
Dermatology	4,003	3,870	3,775	3,796	3,674	3,538	3,405	3,277
Gastroenterology	2,010	1,916	1,748	749	701	633	587	564
Internal Medicine	41,872	38,258	38,532	42,325	40,314	38,690	36,792	34,742
Pediatrics	17,941	17,098	16,650	17,348	16,417	15,665	14,815	14,024
Pediatric Allergy	391	372	398	91	91	82	86	73
Pediatric Cardiology	487	456	441	175	172	146	117	110
Pulmonary Diseases	2,315	2,240	2,137	1,218	1,231	1,226	1,220	1,236
Surgical Specialties	86,042	82,912	81,820	82,192	79,245	76,147	73,267	70,496
General Surgery	29,761	28,603	28,433	29,687	28,756	27,693	26,527	25,493
Neurological Surgery	2,578	2,484	2,419	2,315	2,189	2,045	1,937	1,822
Obstetrics and Gynecology	18,876	18,084	18,017	17,964	1,744	16,833	16,306	15,720
Opthamology	9,927	9,578	9,368	9,083	8,735	8,397	8,108	7,849
Orthopedic Surgery	9,620	9,227	8,869	8,426	7,982	7,549	7,200	6,820
Otolaryngology	5,409	5,272	5,195	5,583	5,429	5,325	5,243	5,185
Plastic Surgery	1,600	1,503	1,414	1,303	1,207	1,133	1,058	993
Colon and Rectal Surgery	667	666	707	644	647	650	662	673
Thoracic Surgery	1,809	1,857	1,822	1,725	1,627	1,477	1,378	1,300
Urology	5,795	5,638	5,576	5,462	5,229	5,045	4,848	4,641
Other Specialties	89,641	89,249	81,970	74,033	70,798	67,271	64,198	61,150
Aerospace Medicine	1,188	1,319	1,456	792	821	788	796	764
Anesthesiology	10,860	10,434	10,112	9,630	9,110	8,644	8,173	7,639
Child Psychiatry	2,090	1,898	1,702	1,080	958	817	694	532
Diagnostic Radiology	1,968	1,540	1,551	49	44	38	32	21
Forensic Pathology	200	197	197	47	49	51	52	45
Neurology	3,074	2,850	2,675	2,466	2,295	2,174	2,015	1,802
Occupational Medicine	2,713	2,746	2,702	1,706	1,727	1,745	1,786	1,814
Psychiatry	21,146	20,328	19,907	19,749	18,875	17,888	16,901	16,049
Pathology	10.283	9,826	9,499	9,471	8,914	8,437	7,861	7,302
Physical Medicine and Rehabilitation	1,479	1,415	1,407	1,208	1,140	1,084	1,022	932
General Preventive Medicine	804	819	839	1,007	1,005	971	922	832
Public Health	3,029	3,075	3,032	1,627	1,679	1,709	1,753	1,778
Radiology	10,524	10,041	9,436	10,727	10,069	9,553	9,063	8,697
Therapeutic Radiology	868	786	732	101	76	56	43	33
Other Specialty	6,929	8,753	6,222	4,101	3,917	3,566	2,775	2,347
Unspecified	12,486	13,222	10,502	10,272	10,128	9,750	10,310	10,563
Unclassified	23,183	21,976	20,720	14,550	14,518	14,963	14,672	14,747

[1] Excludes temporary foreign physicians.

Sources: American Medical Association Center for Health Services Research and Development, *Distribution of Physicians in the United States Series* (1963, 1964, 1965, 1966, 1967, 1968, and 1970 volumes). The specific table used was entitled "Federal and Nonfederal Physicians in United States by Specialty and Activity." This was Table A in volumes 1963-1966 and Table 1 in volumes 1967-1970.

Table III-5. PERCENTAGE CHANGE OF FEDERAL AND NONFEDERAL PHYSICIANS IN THE UNITED STATES AND POSSESSIONS BY SPECIALTY BETWEEN 1963 AND 1970

Specialty	Percentage Change Between 1963 and 1970
Total Physicians	+ 21%
General Practice	- 22
Medical Specialties	+ 36
Allergy	+ 106
Cardiovascular Disease	+ 274
Dermatology	+ 22
Gastroenterology	+ 256
Internal Medicine	+ 20
Pediatrics	+ 28
Pediatric Allergy	+ 436
Pediatric Cardiology	+ 343
Pulmonary Diseases	+ 87
Surgical Specialties	+ 22
General Surgery	+ 17
Neurological Surgery	+ 41
Obstetrics and Gynecology	+ 20
Opthalmology	+ 26
Orthopedic Surgery	+ 41
Otolaryngology	+ 4
Plastic Surgery	+ 61
Colon and Rectal Surgery	- 1
Thoracic Surgery	+ 39
Urology	+ 25
Other Specialties	+ 47
Aerospace Medicine	+ 55
Anesthesiology	+ 42
Child Psychiatry	+ 293
Diagnostic Radiology	+ 9271
Forensic Pathology	+ 344
Neurology	+ 71
Occupational Medicine	+ 50
Psychiatry	+ 32
Pathology	+ 41
Physical Medicine and Rehabilitation	+ 59
General Preventive Medicine	- 3
Public Health	+ 70
Radiology	+ 21
Therapeutic Radiology	+ 2630
Other Specialty	+ 195
Unspecified	+ 18
Unclassified	+ 57

Source: Table III-4.

Another type of extended coverage may be provided through a policy with and "excess carrier." Typically this method is used when an agent has a limit on the amount he can write in a basic policy and a client wants higher coverage. The agent can buy an excess policy from a carrier who specializes in this type of coverage.

Some carriers who have in the past been willing to write excess policies for professional liability are somewhat reluctant to do so now. The increasing severity of claims coupled with the lack of experienced personnel make it difficult for an excess carrier to write this type of coverage.

Claims incurred and claims made

Most of the policies written by American carriers are on a claims incurred basis. The insured is covered for any claims from an incident which occurred or is alleged to have occurred during the policy period, regardless of when the claim is made. The only limiting factors are the statutes of limitations, which vary from state to state.

Lloyds of London has traditionally provided coverage on a claims made basis and a few American carriers are experimenting with this type of coverage. In this type of policy, the insured is covered for any claim made while the policy is in force, i.e., coverage ceases when the policy lapses. If an insured were to switch from a claims made to a claims incurred policy, it would be necessary for him to purchase coverage for any claims based on prior incidents that might be made after the expiration of his claims made policy. Claims made policies are usually written to exclude claims based on incidents that occurred prior to the effective date of the policy.

Most carriers oppose claims made coverage unless the entire system is converted to that type of policy. They point out the problems in providing two different types of coverage and the possibility that doctors may unwittingly be left unprotected if a carrier cancels a claims made policy.

Cancellation and nonrenewal

Policies may be cancelled an any time by the insured by mailing or delivering to the carrier or its authorized agent the policy with a statement of cancellation. Carriers may cancel by mailing or delivering to the insured or his agent a notice of cancellation to be effective upon the expiration of a given time period. This time period is usually ten days; however, some states require at least 30 days notice. Pennsylvania requires 30 days advance notice to the state insurance department of any cancellation or nonrenewal. A few carriers include a 30 day notice in their policies.

While all the carriers retain the right to cancel or not renew, several have instituted a review or appeal process in their group plans. If the carrier decides to cancel, not renew, or restrict the professional liability coverage of a member, the action may be appealed to the professional liability or peer review committee. In some cases, the carrier will not cancel or refuse to renew without the consent of the committee. One group contract provides that not over ten percent of insured physicians can be cancelled in one year.

Consent to settle

Medical malpractice policies have usually carried a provision that the carrier cannot settle a claim without the consent of the insured. Some carriers have eliminated this provision completely. They feel that an individual doctor is not in a position to judge negligence. Other carriers have a provision in group plans that either the individual or the peer review committee (or similar group) must consent in order to settle.

Deductibles

Deductibles are offered on medical liability insurance for two reasons. One is to lower the cost of insurance to those who seldom have claims, or have a limited number of small claims. Another is to provide insurance to those who have had poor claims experience or who are high risk specialties. One carrier surveyed generally gives approximately 15 percent premium reduction for a $1,000 deductible on practitioner policies. Other carriers offer deductibles but require that each case be submitted for rating.

C. INSURERS AND THEIR CHARACTERISTICS

Medical malpractice data are not readily available for the total market. Some insurers maintain detailed, accurate data. Others, smaller firms in particular, have minimal historical malpractice data. Certain other insurers thought to be writers of malpractice insurance declined to provide any data whatsoever. Thus, the data presented in this section are estimates derived from incomplete results of surveys and therefore subject to some degree of error.

Medical malpractice premium volume

Total medical malpractice premium volume was estimated by multiplying an estimate of the number of insured dentists, physicians, and hospitals (see Sub-Section A), by the average premium cost (derived in Sub-Section I) for each category. Policy limits employed in this computation were determined from available data on the distribution of policy limits for each category.

The base year for the computations was 1970. The reported number of dentists, physicians, and surgeons was adjusted downward to allow for those in administration, teaching, retirement, etc.[6] The resulting numbers were multiplied by the ISO national average premium cost. The result was decreased by 15 percent as ISO rates are about that much higher than those carried by direct writers and were thought to be 15 percent higher than the group charges (see Appendix A). This calculation was repeated for the 1960-1969 period with adjustments for the changing mix between physicians and surgeons and the growth rates of the various professions. The results for dentists, physicians and surgeons are displayed in columns one through three respectively of Table III-6.

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[6] The adjustments implied that 96 thousand dentists would buy malpractice coverage; 142 thousand physicians; and 129 thousand surgeons.

The total number of hospitals in the United States has remained relatively constant throughout the period. However, federal hospitals, some state institutions and a few private hospitals self-insure. On the basis of informal conversations with the American Hospital Association staff, a figure of 4800 hospitals[7] was employed to derive hospital medical malpractice premium volume for 1960-1970. The results are displayed in column four of Table III-6.

The total volume, shown in column 5, was obtained by summing over the previous four categories. This sum thus omits all allied health care professionals and paraprofessionals who purchase separate coverage. Their omission is based on responses to the mail survey which requested estimates of these professions' contribution to medical malpractice premium volume. The responses ranged from negligible to less than two percent.

Over the decade total malpractice premium volume grew 507 percent, with surgeons growing 949 percent; physicians, 537 percent; hospitals, 263 percent; and dentists, 116 percent. The impact and magnitude of this growth is further exemplified by the growth of medical malpractice premium as a percent of (i) all property and liability (ii), auto bodily injury, and (iii) workmen's compensation premium volume. Table III-7 indicates that between 1963 and 1970 this percentage grew from 0.4 .o 1.1, 2.3 to 6.1, and 4.6 to 10.4, respectively.

Using other available data, it is possible to make an independent check on the estimated premium volume for physicians and surgeons shows in columns 2 and 3 of Table III-6. Table III-8 shows 1972 premium volume and number of practitioners covered in selected group plans. Column three contains an estimate of the number eligible for participation, column 4 shows the estimated participation rate, column five estimates the premium volume which would occur if all who are eligible participated and column six shows the average premium per practitioner. The estimated premium volume for these seven states and part of California is $110.9 million, for an average of $1,633 per practitioner.

This average is substantially higher than the $942 premium per practitioner implied by Table III-6. Two problems prevent making direct comparisons between these averages. One, although the average premium shown in column 6 varies widely, the group plans are generally more urban in character than is typical of the nation. Two, the group premium volume figures are typically for 1972 and, as indicated in Table III-24, malpractice premium charges have increased approximately 23 percent since 1970. However, 81 percent of the $1,633 average is $1,323, which remains substantially higher than the $942 average of Table III-6.

The 67,900 physicians represented by these group plans represent 31 percent of the U.S. total. Expanding to the

Table III-6. MEDICAL MALPRACTICE PREMIUM VOLUME FOR DENTISTS, PHYSICIANS, SURGEONS, AND HOSPITALS: 1960-1970 (in millions)

Year	Dentists	Physicians	Surgeons	Hospitals[1]	Total
1960	$5.1	$7.6	$19.7	$28.7	$61.1
1961	5.3	7.9	22.4	30.3	65.9
1962	5.4	8.1	25.2	31.1	69.8
1963	5.6	8.9	30.3	32.2	77.0
1964	5.8	9.6	35.5	33.2	84.1
1965	6.4	10.5	38.5	35.1	90.5
1966	7.0	11.4	43.7	33.2	95.3
1967	7.4	15.2	51.7	35.7	110.0
1968	7.7	19.0	59.7	38.1	124.5
1969	8.9	30.2	110.5	63.0	212.6
1970	11.0	48.7	206.7	104.2	370.6

[1] The AHA estimates that the average hospital malpractice premium was $16,465 in 1970 compared to the $21,710 average implied by Table III-6. Also, the AHA claims that 4155 hospitals purchase malpractice insurance, not the 4800 used to calculate column four. The AHA's average figure is somewhat suspect due to their survey's low return rate (43 percent). However their estimate of the universe, 4155, may be more accurate. If it is, the hospital premium volume should fall 13.4 percent and total volume by 3.8 percent. [Hospital Professional Liability Survey, AHA Bureau of Research Services, 1972].

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[7] There are presently 7100 hospitals in the U.S.

Table III-7. MALPRACTICE PREMIUM VOLUME AS A PERCENT OF PERSONAL LIABILITY, BODILY INJURY, AND WORKMEN'S COMPENSATION PREMIUM VOLUME: 1960-1970

Year	As a Percent of Property and Liability Premium Volume	As a Percent of Automobile Bodily Injury Premium Volume	As a Percent of Workmen's Compensation Premium Volume
1960	n.a.	2.1%	n.a.
1961	n.a.	2.2	n.a.
1962	n.a.	2.2	n.a.
1963	0.4%	2.3	4.6%
1964	0.4	2.4	4.6
1965	0.4	2.3	4.5
1966	0.4	2.2	4.1
1967	0.5	2.4	4.2
1968	0.5	2.5	4.3
1969	0.7	3.9	6.6
1970	1.1	6.1	10.4

Source: Malpractice premium volume, Column 5 of Table III-6; Insurance Information Institute Yearbook, *Insurance Factors.*

Table III-8. 1972 PREMIUM VOLUME AND PARTICIPATION – SELECTED PRACTITIONER GROUP MALPRACTICE PLANS

Group Plan	# of Insured Physicians (1)	Premium Volume of Insureds (2)	Total Physicians Eligible (3)	% Participation (1÷3) (4)	Extrapolated Premium Volume (2÷4) (5)	Average Premium per Practitioner (6)
New York State	21,000	$34,000,000	27,000	78%	$43,500,000	1,611
Florida State	4,400	15,000,000	7,000	63	23,800,000	3,400
L. A. County	5,200	13,000,000	8,500	61	21,300,000	2,506
Northern Cal.[1]	5,500	5,000,000	7,500[2]	73	6,800,000	907
Virginia	3,100	1,050,000	3,200	97	1,080,000	338
Minnesota	4,200	1,100,000	4,300	98	1,120,000	260
Colorado	800	500,000	2,400	33	1,500,000	625
New Jersey	7,000	10,400,000	8,000	88	11,800,000	1,475
Total	51,200	$80,050,000	67,900	75%	$110,900,000	6,633

[1] 1968 figures

[2] 1971 # of insureds, total eligible not available

Source: Appendix A

U.S. total implies a 1970 premium volume of $290 million (110.9 x 0.81 ÷ 0.31), which is 14 percent higher than the total of columns two and three of Table III-6. As $290 million is significantly higher than the $255.4 estimate from columns 2 and 3 of Table III-6, the estimates presented in Table III-6 seem reasonable.

Estimated 1970 malpractice premium volume of 370.6 million dollars seems reasonable as it is approximately one percent of all property and liability premium volume. However, the Malpractice Commission surveyed 31 malpractice insurers. The sum of the 31 firms' malpractice premium volume was $205.4 million, which is 55 percent of the $370 million estimate. Part of the difference may be explained by the omission of approximately 30 smaller malpractice insurers from the Commission's survey frame. It is almost certain that the "true" malpractice premium volume is between $205.4 and $370.6 million.

Losses and claims

A historical series of losses incurred and paid and claims open and closed[8] was developed from the survey returns. Data from responding insurers were expanded to an estimate of the total market based upon the responding insurers' share of the market. The results are displayed in Table III-9. These preliminary results imply an 81 percent increase in losses incurred with only a 12 percent increase in losses paid. The claims opened (which represents claims still open) and claims closed show a growth of 43 and nine percent, respectively. These data imply an increasing frequency and severity of claims and, on the basis of incurred losses, severity is the dominant force. Some of the differences between losses incurred (column 1) and losses paid (column 2) is accounted for by the long interval required to settle a typical malpractice claim.

The ratio of losses incurred to premiums shown in Table III-9a, indicates that the industry is recovering from its period of inadequate rates during the mid and late 1960's.

D. MARKETING OF MEDICAL MALPRACTICE INSURANCE

Professional liability or medical malpractice insurance is marketed either through agencies or through direct sales to the insured. Carriers which rely on the agency system are by far the dominant factor in the market.

Agency system

Both stock and mutual companies use variations of the agency system. The majority of agents are independent and offer insurance through several carriers, though they often place a larber part of their business with one carrier. General agents who are affiliated with a carrier typically offer all lines of insurance that the carrier offers. Some carriers utilize large brokers, somewhat like wholesalers, to market their insurance to agents.

Table III-9. ESTIMATED MALPRACTICE INSURANCE TOTAL: LOSSES INCURRED, LOSSES PAID, CLAIMS OPEN, CLAIMS CLOSED: 1960-1970[1]

Policy Year	Losses Incurred (millions)	Losses Paid (millions)	Claims Open (thousands)	Claims Closed (thousands)
1960	$51.4	n.a.	n.a.	n.a.
1961	53.4	n.a.	n.a.	n.a.
1962	57.1	n.a.	n.a.	n.a.
1963	59.7	n.a.	n.a.	n.a.
1964	84.2	n.a.	n.a.	n.a.
1965	104.8	n.a.	n.a.	n.a.
1966	110.2	$58.2	18.2	20.3
1967	112.0	51.9	18.9	19.0
1968	113.4	49.5	18.2	16.4
1969	146.7	47.0	25.2	19.0
1970	199.4	65.3	32.9	22.1

[1] As the figures displayed in Table III-8 rely on the estimates of total malpractice premium volume, their absolute value is a dependent on the estimated premium. However, the trend in losses incurred and paid and claims open and closed is less sensitive to the premium estimates.

Source: NPA Survey of Malpractice Insurers.

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[8] As of mid-1972.

TABLE III-9a.

RATIO OF LOSSES
INCURRED TO PREMIUMS: 1960-1970

Year	Ratio
1960	0.84
1961	0.81
1962	0.82
1963	0.78
1964	1.00
1965	1.16
1966	1.16
1967	1.02
1968	0.91
1969	0.69
1970	0.54

Agents range from small, neighborhood operations to large statewide and multi-state operations. Smaller agencies normally write medical malpractice chiefly as a service to their physician clients and malpractice is not a major part of their business.

Larger agencies become involved in many aspects of the business through participation in underwriting selection, claims handling, loss and claims prevention, more extensive marketing, and providing additional services to the insured. In addition to providing individual policies, agents are usually involved in the administration of group plans.

Expertise of the agency can be a significant influence on success of the carrier, since agents do much of the basic underwriting selection, policy administration, and claims reporting (and sometimes claims adjusting). Some carriers cited the lack of knowledgeable and trained personnel both in the agencies and on their own staff as a major problem in writing more medical malpractice insurance or in improving their experience. Some carriers expressed serious reservations about writing this type of coverage through agencies which are oriented primarily towards other kinds of insurance and which lack knowledge and experience in this field.

Agent's commissions range from a few percent up to twenty percent of the premiums. Agents writing individual policies usually receive from ten to twenty percent commission. Those agents who write a large number of individuals as part of a group-sponsored or endorsed plan often receive a commission negotiated on the amount of services performed and the level of production (number of policies written).

Carriers often curtail commission on premiums for higher risk specialties. An agent spends essentially the same amount of time marketing a policy to a general practitioner as to a neurosurgeon. The premiums for the neurosurgeion will be several times larger than the premium for the general practitioner and carriers feel that a flat commission rate is not appropriate. In some agent agreements, the commission structure is said to contain a contingency arrangement, which means an agent's commission may be adjusted on the basis of claims experience.

Direct selling

Three carriers are known to sell a significant level of medical malpractice insurance on a direct basis. Marketing and servicing of policies is done through salaried field representatives. One carrier writes only individual policies, and maintains field offices which handle many of the functions agents handle for the other carriers. The primary difference is that they are salaried employees rather than independent agents who receive a commission on the business they write and service. The other direct sellers concentrate their marketing efforts on group plans. The direct sellers' rates are somewhat lower than ISO rates, but it is impossible to determine whether this difference is a result of lower sales cost or better loss experience or some combination of both.

Group sponsorship or endorsement

Some group plans are sponsored by a medical or professional group such as a state medical society or a hospital association. This type of plan is usually designed for the sponsoring organization, which participates in administration of the plan. Other group plans are simply endorsed, with little or no participation in administration. Most carriers interviewed prefer to sell group plans rather than individual policies, and most of their marketing activities relate to group plans. An extensive discussion of group plans is contained in Section E.

E. OVERVIEW OF GROUP PLANS

Individual case studies of nine group insurance plans—three hospital and six physician plans—are contained in Appendix A. These studies imply that group plans are "here to stay" and the number of such plans will probably continue to increase. Group plans operate in a variety of ways, as is amply illustrated by these case studies. The impact of these variations is difficult to isolate however, because of the limited number of plans studies. The next part summarizes major variations which were found, and compares group plans with the individual market. Parts 2 and 3 summarize findings for hospitals and physicians, respectively.

The impact of group plans

Variations in group plans

Hospital association plans are either sponsored or endorsed. Under a sponsored plan the association usually performs some of the administrative and selling duties such as encouraging hospitals to join or collecting application forms for the insurer. Sponsoring associations also appoint an insurance committee which reviews underwriting practices, claims, rate changes, and competing proposals from other carriers. Endorsement, by contrast, is a simple recommendation that member hospitals obtain their coverage from a particular insurer, and endorsement may or may not include actual "shopping" for an insurer.

Each group arrangement leaves final underwriting decisions to the carrier. Under sponsored plans the association is typically solicited for recommendations on underwriting, and it appears that carriers generally follow these recommendations. Two of the three hospital plans studied were sold by agents, with the third plan being sold directly to the hospital association by the carrier.

Practitioner plans display a significantly higher degree of variation than hospital plans. All practitioner plans are sponsored, although duties of sponsorship vary. Administrative duties of the sponsoring medical society range from collecting application forms and billing to claims handling and recommendations on underwriting of individuals whom the carrier considers to be high risk. All six group plans were negotiated between their respective carriers and medical societies. Three of the six medical societies took the initiative of developing a "model plan" which they wanted and then used their model as the basis for shopping and negotiating with carriers. In the other three instances, plans were developed and sold by the carriers. Among other things, the negotiated terms specify the carrier-group relationship, including the appeal procedure available to physicians denied coverage, up-rated, not renewed, or cancelled. Some plans admit, for a probationary period, any doctor who joins the society.

Underwriting questions raised by either the insurer or a member of the medical society are generally reviewed by the society's screening panel. In one of the six plans studied the panel has the power to overrule the insurer's action; when appeals are recognized in the other plans, decisions of the panel are generally accepted by the insurer. Recommendations to insure a practitioner with a high loss record may include placing limits on his practice (such as no surgery), deductibles, uprating, limits on the coverage written, or some combination.

Insurance policies issued under group plans include the customary provision which requires that a doctor consent to any settlement. However, rules of the group plan generally permit a review panel to arbitrate and issue a binding decision when the physicians and insurer disagree on settlement. Other assistance in claims handling under some plans includes provision of witnesses and consultation. Finally, under some plans an insurer may be required to compensate a physician as expert witness for time lost during claims defense.

One important factor which some plans include gives the society the right to audit the group's malpractice premium, loss, and loss adjustment expenses. This important right enables a group to more readily "shop" its plan with other carriers as well as help regulate carrier's rate making. Of the six practitioner plans studied, the plan with the lowest retention factor has included this right to audit (and the society does in fact cause an audit to be conducted each year) for the longest period of time. Two plans have recently found new carriers at substantial initial decreases in rates.

Collection and review of statistical data were undertaken in extensive detail by three of the group plans studied, usually by the broker on behalf of the medical society. Two plans, notably Florida and Los Angeles, were able to negotiate reduced rates when acquiring a new carrier. Also, in all three groups, the classification structure for specialties has been expanded and refined from the standard ISO classifications. (New York has eight classifications, Los Angeles 11, and Florida six).

Methods used to enroll members include assigning primary responsibility for selling the group plan to an exclusive managing broker (e.g., New York), to a large agency through independent local agents, to using the carrier's local agents. In general, the lower the participation rate and the larger the number of agents involved in enrolling society members, the greater will be the portion of the premium allocated to sales commissions or selling expense.

In addition to causing higher sales expenses, low participation rates and fragmentation of the society limit what the society can deliver to a carrier and thus decrease effectiveness of the society's bargaining power when shopping its plan among carriers.

Group versus individual policies

Hospital plans. Group plans, by their nature and size, either attract specialist carriers or convert nonspecialists into specialists. However, in a comparison between insurance sold through group plans or by knowledgeable carriers who write individual policies, it is difficult to see that group plans hold any great advantage for hospitals.

An individual market, i.e., a market composed of carriers who write policies on individual institutions, may simultaneously consist of some carriers who write a relatively large number of hospitals (albeit individually) and are quite knowledgeable, and other carriers who for one reason or another write relatively few. This market is highly specialized, with little room for the carrier which does not know what it is doing. The market suffers little when such carriers withdraw and leave it to those who know, understand, and can adequately or properly service the market.

During historical development of group hospital plans, it seems that when charitable immunity was the prevailing legal doctrine it may have created a situation where hospitals throughout the state had not bought malpractice insurance and, therefore, agents had not sold it. Hence there was a justifiable degree of ignorance on the part of most agents and hospitals about purchasing malpractice insurance. Because of this, gravitating towards a group plan was simply following the path of least resistance. It may be, however, that group plans make less sense in today's market than previously.

Physician group plans tend to create a monopoly-monopsony market within a state, but at the same time they are likely to offer enough advantages to a majority of the insureds to offset the cost or problems of such a market. In some groups, an advantage accrues to high-risk physicians at the cost of the low-risk ones. Under the generally easier under-writing screen of groups, high-risk physicians may obtain medical malpractice coverage at the same rate as low-risks. Low risk practitioners, however, may continue to remain in the group and subsidize the high risks out of fear that they will become a high risk. This subsidy helps assure a market for the hard-to-insure. Also, group plans may offer options which are not always available in the individual market. The group, through peer review, may help the insurer determine the appropriate deductible or up-rating, and these provisions give a high-risk practitioner an opportunity to obtain insurance at some price.

Some plans reduce or minimize the subsidy to high-risk specialties because their volume of data permits development of rate classifications which are more "equitable" than those for individuals. A good central data agency would remove this advantage. Group arrangements do provide a good mechanism for setting the maximum loss which will be used to set class rate differentials. Above this maximum losses are pooled to determine expansion factors for all physicians. Since setting of the maximum determines distribution of losses between classes, the joint decision by the group and insurer (stop-loss feature) may be preferable to a decision by the insurer alone.

Peer review and the medical society's insurance committee offer the physician a feeling of more control over his malpractice insurance situation than he has as an individual purchaser. As a member of a group with millions in premium volume, any insurance problem or questions will receive at least as much response from an insurer as he would if he were an individual policy holder. The satisfaction derived from this power appears to be a major reason for popularity of group plans.

Another major reason for popularity of group plans is rates. Logically, group volume should decrease selling or production costs and therefore decrease premiums. This logic could not be verified empirically, however. In fact, the market share of some plans ranged between 50 to 75 percent because many physicians apparently found rates lower outside the plan. Since these physicians are usually "good-risk" types, any straightforward rate comparisons without further investigation would be misleading.

When individual policies are available from a variety of insurers, physicians have some assurance of competition for their business without being forced into a medical society. However, a successful group plan (one with a high participation rate) drives individual writers out of the state and tends to drive remaining physicians into the group plan. Once in, physicians may be forced either to accept all group decisions, practice without insurance, move to another state, or retire. This limited set of choices gives the medical society one strong enforcement club and could prove burdensome to any individual(s) who might, for any reason, desire to "violate" medical society traditions and, for example, pioneer new concepts or methods of health care delivery.

Hospital association group plans

Approximately 35 state hospital associations have group professional liability. The California, Pennsylvania and Texas hospital associations were welected for study.[9] This section will describe the results of these case studies.

Historical perspective

The primary force which necessitated hospitals acquiring a high level of professional liability coverage was demise of the "charitable immunity" doctrine. Prior to its demise, application of this doctrine by the courts protected hospitals and similar institutions from individuals seeking compensation for injurious or wrongful acts arising in the hospital. This immunity from liability derived from an underlying social attitude that nonprofit service institutions existed for the benefit of each member of society and therefore the right of a particular individual to threaten the economic or moral stability of that institution through litigation would endanger all of society. Thus hospitals were shielded from attacks by any individual regardless of whether the hospital had harmed the individual through negligence.

The charitable immunity doctrine was in force for several generations, but began to encounter opposition as social attitudes changed. Some felt that hospitals had abused the privilege of immunity whereas others simply believed that it was socially beneficial for hospitals to be responsible for their own acts to individuals. Depending upon the state, and usually after success of test cases, the shield afforded by the doctrine of charitable immunity steadily eroded. In many states removal of immunity came swiftly, and numerous hospitals in a state simultaneously found themselves needing protection. State hospital associations, seeing a common need among their members and believing in their service role to these members, in many instances, took steps to alleviate the problem.

Participants

In the three group plans studied, the parties involved in operating the program are quite similar—the endorsing or sponsoring association, the carrier offering the coverage, and a broker or agency as liaison between the association and carrier. The policy for each hospital in these plans covers any employee of the hospital, members of the board, trustees, and administrators. Usually interns and volunteers are covered while performing duties for the hospital.

Insureds in these plans typically are private hospitals, Federal hospitals, state or local government hospitals; clinics and health maintenance organizations usually do not participate in the group plan because they are able to obtain government coverage or they self-insure.

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[9] The universe of group plans and selection process are described in Appendix B

Premiums

The rate for an individual hospital is determined by one of two basic approaches. The *classical* approach is to experience rate a hospital according to its previous claims record. The *level premium* approach rates each hospital identically (i.e., without regard to previous loss experience), with any difference in total premium based on characteristics such as size or number of employed doctors.

Regardless of the approach, the total premium for any individual hospital consists of: (i) the "pure premium," which is the actuarially determined rate needed to cover losses and loss adjustment expenses, and (ii) a "retention factor" which is the company's cost of doing business.

The pure premium consists of three rating factors (i) the per bed rate, (ii) the rate per 100 outpatient visits, and (iii) the number of full-time employed physician equivalents. The per bed rate applies to the average number of occupied beds for the premium period. The rate for every 100 outpatient visits to the hospital is either a percentage of the per bed rate or a rate based upon experience related to outpatient care. In three state plans studied, a rate is also charged for the number of full-time physicians employed by the hospital. Part-time employed physicians are accumulated into full-time equivalents. This factor causes teaching hospitals, which will usually have more physicians on the payroll, to pay higher premiums.

The retention factor is composed of several elements: administrative overhead, claims services, taxes, selling, production costs, and under-writing profit. Since savings can be realized in selling and servicing greater volume, group plans reportedly strive to achieve a lower retention rate than individual policies offer. Whether they, in fact, achieve such savings is not clear, however. Hospital group plans are a recent phenomenon in *most* states and participation is not high, so these benefits may not materialize until greater participation is reached and the plan has operated for several years. It is certain, however, that associations can apply pressure and constant monitoring on the carrier to keep costs down and thus lower the retention factor, whereas individual hospitals occupy no such bargaining position.

A level premium rated program simply sums the pure premium and retention factor. An experience rated program derives the premium in the same manner, but the underwriter surcharges or reduces the premium based on an evaluation of the previous loss experience of the hospital. This evaluation may also include a judgment of how efficiently the hospital operates, its cooperation with safety engineers and concern for safety prevention.

Eligibility

As a general rule, every member in good standing is eligible to participate in the hospital association's group professional liability program. A hospital may be excluded by the carrier or by the insurance committee of the association when its loss experience has been extremely poor. This fact alone will not prohibit the carrier from accepting the risk, but the hospital may be rejected if it is determined that the hospital's management is not willing to implement suggestions of the safety specialist or cooperate to alleviate the conditions most likely to cause incidents. The cooperation of hospital management and staff is particularly crucial in level premium programs such as the California plan because the incentive of individual experience rating is absent. In practice few hospitals are rejected without being given a probationary period in which to "clean house."

Advantages to insureds

Availability. The demise of charitable immunity caused a short run crisis for hospitals without professional liability coverage. Insurance protection was necessary immediately in order to operate. Establishment of a group plan offered this immediate availability and eliminated any need for hospitals to seek an individual carrier willing to cover them.

The group plan also makes coverage available to hospitals which are high risks due to previous loss experience. The associations visited thought the majority of individual carriers had established highly selective underwriting criteria, desiring only low risks. High risk hospitals were either left without coverage or received coverage at a surcharged rate. Certain carriers supposedly required that other insurance coverages for the hospital be insured by them before professional liability coverage would be accepted. This was especially true for smaller hospitals under 50 beds whose premium for professional liability was not considered sufficient for the risk. One benefit of the group plan was availability of coverage with few, if any, requirements on other coverages.

Loss prevention. While availability of coverage provides for short-term needs, the loss prevention aspects of the plan are a hedge for the future. In the three hospital plans studied, both the association and the carrier believed the control of losses to be a crucial factor in future stability and success of the program. For this reason, a substantial effort is expended on safety control and loss prevention.[10]

California Hospital Association states that a fundamental feature of their program is designed to improve the quality of patient care. Their approach to this end is to minimize potential liability and this can be accomplished through loss control activities. Both the carrier and the Association, in this case, are committed in expense and effort to carry out this objective.

The advantage of a group plan is a volume of premium to the carrier sufficient to justify the development of statistical studies and expert engineering services. The Association's role is to take an active and direct interest in reviewing new developments, making recommendations to insured members, and seeing that they are implemented.

The individual carriers rely on experience rating to provide the hospital with incentive to improve itself; however, a total program commitment is absent.

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[10] See individual hospital group write-ups in Appendix A for details of these efforts.

Claims handling. Advantages of claims handling offered to hospitals insured under a group plan are a function of the size and premium volume generated by the group. Large groups enable the carrier to employ claims adjustors who specialize in and become thoroughly familiar with professional liability claims. A rapport may subsequently be established by the hospital and claims adjustor so that investigative procedures yield better disclosure of pertinent information, which results in an improved course of action for defending a case. Each of the plans studied have full-time professional liability claims specialists who can render more experienced judgment of incidents, their potential as claims, and the setting aside of an appropriate reserve. This may allay many of the fears hospitals have concerning reserve practices.

Early incident reporting is important to the claims aspect of a carrier's service. A few of the benefits derived from the immediate reporting of incidents include: early investigation, determination of potential claim and whether to settle early or establish defense, and advance payment to patients clearly injured. Individual carriers receive these same benefits; because of greater participation, however, the group carrier may provide data processing capabilities to record and tabulate all incident reports. This printed tabulation is then reviewed for developing trends by the carrier's claims unit and the association, thereby providing a valuable source for safety control. Employers' of Wausau, group carrier for Pennsylvania, expects more than 50,000 reported incidents in 1972. The other two plans have similar systems.

Judgments to defend or settle malpractice claims will be made in the best interests of all the members, not just to get one particular hospital "off the hook." Thus, in order to get a favorable court decision which may set precedent for other cases, the carrier may decide to defend a case which it could otherwise settle more quickly and with less expense. If successful, long-run settlement costs may be reduced. Two of the plans studied put special emphasis on this rationale.

Insurance committees. The hospital associations of California, Pennsylvania, and Texas all have an insurance committee which handles every group program offered to the membership. Much of the committee's time is spent on professional liability as it has been the most troublesome.

The association's insurance committee is the hospital's protection against arbitrary decisions by the carrier. Activities and responsibilities of the committees include:

- Review eligibility of new participants
- Review any renewal or cancellation problems
- Require full financial disclosure from carriers
- Review all policy provisions and rate changes
- Analyze incident reports, loss data, and reserve status of all insureds
- Initiate educational programs for claims prevention
- Serve as final appeal board for disagreements arising from plan.

California and Texas have sponsored programs, and their insurance committees exhibit more involvement in the above areas than Pennsylvania, which is an endorsed plan. There is a tendency for the committee to become much more involved in the program as time goes on and the diverse aspects of the malpractice problem are realized.

Advantages for carriers

Broader base for risks. Professional liability insurance is similar in theory to other lines of casualty insurance in that the greater the number of participants and greater the premium dollar volume, the easier it becomes to meet certain risks and to absorb losses. Some uncertainty always exists when making underwriting decisions, and carriers seem more willing to accept questionable risks in group programs which have a large base over which to spread the additional risk.

Advantages to consumers

At this time, the overall effect of group program efforts in improving the quality of patient care is difficult to measure. Nevertheless, the success of some programs, notably the California Hospital Association plan in its early development, in reducing the frequency of certain incidents is noteworthy. In 1954, when California adopted its plan, the number of bedrail incidents was 40 percent of the total reported incidents. By June of 1958 80 percent of insured hospitals had bedrails installed and the remaining 20 percent were on a planned purchase program, with the number bedrail incidents and resulting claims significantly reduced. Additionally, the "lost sponge" incident was a major problem causing deaths and heavy claims to the program. The insurance council recommended that all sponges be radio-opaque and a fourth sponge count be instituted. In 1957 only one sponge loss was reported.[11] The more recently initiated group plans are also experiencing early success in minimizing the most obvious and controllable incidents. Efforts to improve the techniques and procedures of medical care in the prevention of incidents are less discernible.

Innovations triggered by the incident reporting system and recommended by the association to the hospitals obviously benefit the patient. Group hospital plans in general have experienced success in controlling and improving the most visible of safety hazards. Whether success is more characteristic of group plans than individual has not been determined.

Disadvantages to the insured

An association-sponsored group plan typically has the most liberal underwriting criteria for entry into the plan. However, after the initial survey is complete and the probationary period runs out, it may happen that an individual hospital which is rejected by the group plan cannot be insured elsewhere. Other carriers would have knowledge of the association's denial and the awareness that denial occurs only after extensive analysis and consideration. This problem becomes more severe as the group plan participation rate increases and the number of individual carriers decreases within the state.

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[11] Jack, J. Fulton, "The California Experience," *The Hospital Forum*, June 1958, pp. 6-7.

Eligibility. In group plans where selling is handled by a designated broker or exclusive agent, many hospitals have had to forego long-standing relationships with local independent agents. This has been an area of contention with many hospitals and the unwillingness to do this is a primary reason for lower participation than the association would like.

Premiums. Regardless of whether experience or level premium rating is used, the experience for every hospital in the group program affects the rates. The individual hospital with a good loss record will suffer less when it benefits from an experience rating adjustment, but the loss trend of the group will still be reflected in each member's rates. In a level premium program, each member shares directly with the experience of the others and any rate adjustments are shared uniformly by all. Thus, groups may find it difficult to recruit low-risk hospitals into the plan. California uses the level premium concept, while Pennsylvania and Texas experience rate their hospitals.

Claims defense. Sublimation of the individual hospital to the group permits a longer-term approach to claims defense. A decision to defend a particular malpractice suit may be beneficial to the whole group in the long run while resulting in increased short run costs which can be detrimental to the individual hospital in an experience-rated program. In such cases, an early settlement is usually desired by the hospital defendant. However, sublimation of the individual hospital to the group permits a longer term approach to claims handling.

Heavy losses. The reasoning that where the potential gain is the greatest, the potential loss is also greatest holds true for the carriers of group professional liability plans. The association and carrier usually agree (albeit in formally) that the carrier will not terminate the plan after a year or two of adverse experience. This understanding, together with the fact that the lag between incident and settlement is several years, may destine the carrier to several years of heavy losses. Historically, losses for carriers with group plans which were unsuccessful have been several millions of dollars, much of which is paid after the carrier left the program.

External control. The power executed by Association insurance committees can lead to a weakened role played by the carrier in determining the direction and thrust of the program. Many times the carrier's commitment to the association is so strong that the carrier will absorb short term losses. The carrier also receives pressure from the broker and association to expand its service personnel and capabilities. The disclosure of financial and claims information also places added responsibility upon the carrier. Although these efforts may be in the best interests of the program, implementation requires expenditures, time, and additional personnel. The carrier may also feel that having to deal with the association on defense matters impedes the settlement process and hence costs more money.

Conclusions and recommendations

In terms of a viable professional liability insurance market for hospitals, the existence of a group plans has done two things. First, they evolved at a time when the professional liability insurance market composed of many individual carriers was experiencing difficulty in pricing this line. The hospitals also were in serious trouble because of changing social attitudes. Group plans met these problems in part. Second, group plans brought a highly competitive situation in terms of major carriers vying to establish group plans. In some states individual carriers met the competition of the group by lowering their rates to low risk hospitals (cream skimming), or by lowering their rates in general. However, once a group plan has a high level of participation, the individual carrier may not be able to compete.

Premiums. At this time it seems that lower premiums have not been a characteristic of group plans. The advisory rates of the ISO have typically been followed by the Pennsylvania and Texas group carriers, deviations being due to experience rating. In these two states, there is no evidence that experience rating has had the effect of reducing the average premium paid per hospital. Actually, individual carriers have been able to offer lower rates for supposed better risks. One reason lower group rates may not occur is because carriers have stressed the service aspects of the plan. These services; i.e., loss prevention, specialized claims handling, incidence reporting, centralized defense, etc., have cost the carrier money to develop. The insured is promised better service and invests in the prospect of rate stability and even rate reduction over the long run. In level premium programs, the objectives of lower rates and improved claims prevention provide the motivation for group participation.

Perhaps the most important function group plans have performed is to increase the awareness of and efforts directed toward loss prevention. In all three group plans safety committees have been initiated within member hospitals and standard safety control practices implemented due to the activities of safety specialists and association concern. Hospitals have taken responsibility for increased patient loads and more complex medical care. These added responsibilities have made it necessary to adopt stricter safety controls. Group plan activities may provide more of an impetus to do this, than individual policies.

Association participation. In the three group plans studied, the association through its insurance committee is involved to varying degrees with the operation of the program. This involvement takes several forms which distinguishes the group concept from individual coverage: i.e., review of rates, reserves and losses; advice on

TABLE III-10

PARTICIPATION IN GROUP HOSPITAL PLANS

State Association	Estimate of Members Eligible for Coverage	Members Insured in Group Plan	Percent Participation	Group Plan Carrier
California	600	400	67%	Farmers Group
Pennsylvania	300	100	33	Employers of Wausau
Texas	425	165	39	Argonaut
Totals	1325	665	51	

eligibility; monitoring quality of care and loss prevention activities.

The role of the association affects the insured hospitals to the extent that they must conform to the wishes of the association in carrying out the program. This means that safety committees must be active in each hospital, loss prevention activities must be maintained, and uniform standards of care must be upheld. Group plan coverage is a means for the association to be sure these objectives are carried out.

Recommendations. These three case studies offer little conclusive evidence to recommend group professional liability plans for hospital associations. The group concept is still in its infant stages. Very few group plans have existed long enough to either reap the benefits initially proclaimed or to obtain enough loss experience to feel comfortable with rate-making techniques. However, associations which are investigating a group arrangement for insurance should profit from the case studies on hospital associations in Appendix A.

These studies describe the development, implementation, and operation of group plans with emphasis on how each plan met particular problems during these three stages.

Group plans for physicians

Six practitioner group professional liability plans were individually studied. Four state, one county, and one national plan were included:

- Florida Medical Association
- Minnesota Medical Association
- New York State Medical Society
- Virginia Medical Society
- Los Angeles County Medical Association
- American College of Obstetricians and Gynecologists

This section reviews the highlights and characteristics of the group plans and discusses the advantages and disadvantages to the parties involved.[12]

Interest in group plans by medical associations and societies throughout the country is evidenced by the growth of these plans in recent years. Currently, there are more than 40 state and county group plans as well as eight programs sponsored by national professional organizations (see Appendix B).

The group plans studied here are "old", the newest having been established in 1961. They represent geographical diversity, a wide range of size (covering 650 to 21,000 insureds), diversified policy features and program characteristics, and different degrees of association involvement.

Major features and characteristics

Availability. One of the most important features of group plans is their availability. Some physician societies claim that to provide availability was the principal reason their group plan was undertaken. Group professional liability insurance plans for physician societies extend to all members of the society. General practitioners, surgeons, and all other specialty groups are eligible for coverage. Physicians who practice in government health facilities or teaching hospitals are also eligible, but they generally obtain coverage through their institutions. Physicians who form a partnership or corporation can also obtain insurance through the group plan. Essentially, the availability of a group plan and the relative ease of access to the group offers an alternative to seeking individual coverage and may be the only perceived alternative for some physicians.

Brokers and agents. When seeking a group carrier, most societies will retain the services of a large insurance broker. The broker will usually develop a program with the society and then negotiate with several carriers to find an acceptable plan. In addition to marketing and collecting of premiums, the role of the broker may include gathering of statistical information (including claims abstracts), general administration of the plan, and primary liaison between the society and the carrier. For this service the broker receives a percentage of total premium volume. Even where brokers are utilized, carriers will maintain direct communication with the society.

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[12] A case study of each group is found in Appendix A.

Some carriers rely on their local agencies to enroll physicians in the plan, and the carrier deals exclusively with the society rather than through a broker. Local agents employed by the company sell individual policies and are the primary communication source for the insured physician. In these cases, the carrier will administer and service the plan either through a regional office or at the home office.

The broker or agency arrangement is vital to the participation rate in the plan. Often the smooth and successful operation of the program is dependent upon the society-broker-insureds relationship.

Rating. Of the six physician group plans studied, all rate classification structures were based upon the type of practice. Group plans typically adopted a classification structure similar to the one used by the ISO, with general practitioners in lower-rated classifications and specialty practices such as neurosurgeons, or anesthesiologists in the higher-rated classifications. Some group plans have subdivided the rate structure to include more classifications, e.g., the Los Angeles County Medical Association's plan has eleven different classifications and the New York State plan has eight classifications. Innovations in this structure also exist as seen in the Florida Medical Association plan's separate classification for emergency room physicians.

Each classification is assigned a rate for all physicians within that category. The assignment of specific specialties within a classification and the rate applied to them is based upon previous loss experience for physicians in that state or county. In a few state society plans, a geographical differential is used for certain areas, e.g., Dade and Broward Counties constitute a separate rating territory in Florida and New York State contains four separate rating territories.

Several group programs have an initial agreement for guaranteed rates over a specified period of time such as two years. In addition, all rate or classification changes must be reviewed by the society and approved by the state insurance commissioner. A few recent plans allow premium payments on a quarterly basis, a more manageable payment system for the physician.

Coverage is offered at varying limits depending on location and specialty. Layers of excess liability coverage and umbrella coverage are available upon request. Professional liability coverage is usually offered as part of a comprehensive policy package which may include personal liability, office premises liability, personal injury and bodily damage liability as well as excess coverage for automobile, aircraft, and watercraft liability. However, the professional liability coverage typically constitutes all but a small portion of the total premium.

The retention factor applied by carriers to group policies consists of the cost of undertaking the plan. It is believed that this factor can be lowered in group plans and represents a potential for bringing the rates of group plans below that of individual carriers. Economies of scale in marketing and administration may be realized under the group arrangement, and these savings are reflected in the allocation of a higher percentage of premium dollar for losses and claims adjustment. One probable area of lower costs is the reduced broker's fee resulting from substantial premium volume. In cases where a single broker for the plan does not exist and the carrier handles selling and marketing of the plan through its agency system, the commission may be lowered because of the society's efforts in directing physicians to appropriate agents. Sales work necessary to acquire this "captured" business does not warrant standard commission fees. Also, as specialized service units are established over the life of the plan, cost savings may be realized from more efficient operations. Although assertions are currently being made proclaiming lower retention factors for group plans, the existence or extent of these savings has not been determined.

To insure against excessively high premium charges and to guarantee the return of any realized administrative savings, most recent group plans include a premium refund or diviend provision whereby any excessive premium is returned to the society. The Los Angeles County plan has the unique feature in which the carrier returns a four percent investment income from loss reserves.

Another rating feature written into some group plans is the "stop-loss" feature. This provision limits the amount which the carrier can apply to its experience rate for any given class. For example, if a case is settled at \$100,000 and the "stop-loss" feature is based on \$25,000, then only \$25,000 will be considered as loss experience for that class in developing new rates and issuing dividends.[13] This provision is not unique to groups. However, the feature does protect a particular class of insureds from getting a rate increase due to a few exceptionally large losses by spreading the entire loss over the entire group. It seems more appropriate that the magnitude is determined jointly by the group and the insurer rather than the insured alone.

Group plans generally use a more detailed statistical reporting system than ISO. Consequently, they tend to refine the rate structure more in terms of both specialities and geographical subdivisions. While the number of rating classifications may not differ significantly from ISO's, this refinement of data gives group plan carriers and associations the capability to review each specialty and county for possible shifts in participation and loss experience.

Peer review. A feature which medical societies believed essential to the success of a group program is physician control through peer review committees. A typical peer review committee is composed of physicians representing various specialties and different county societies. Some group programs have the peer review function primarily at the county society level.

Responsibilities of these committees is diverse and varies in extent for each group plan. One primary responsibility is the review and advice rendered by the committee for any given claim brought before it. The committee is asked to analyze the claim and give a medical opinion as to whether the claim represents negligence by the physician. A decision can then be made by the carrier, attorney, and peer review committee whether to settle or defend the claim.

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[13] The effect of the "stop-loss" feature is discussed in more detail in Sub-Section H.

Another area of responsibility for the committee is in matters of eligibility. Any question about a physician's eligibility for coverage, his qualifications, or loss experience is referred to the committee by the carrier or by appeal from the physician. Although the carrier usually retains the right to make final underwriting decisions, recommendations of the committee are usually followed.

The peer review committee is also an excellent forum for initiating prevention activities. Members of the committee usually represent a wide spectrum of physicians and medical institutions. Experiences gained from reviewing claims is passed on by these physicians. Discussions relating to trends and patterns of claims incidence are also held.

Several large state plans have delegated the peer review responsibilities to county societies. Because of the large number of cases to be reviewed and the familiarity physicians have with their particular county, it is felt that the county societies are better equipped to judge cases pertaining to their members. The greatest advantage is probably in the area of claims prevention. Because state society meetings are less frequent and less well attended, the county society is better able to undertake educational programs and to sponsor lectures and demonstrate new medical procedures and safety methods.

Availability. The group professional liability plan offered by state and county societies. is available to any member of the society. Eligibility requirements are based primarily upon past loss experience. Unless a physician has been deemed negligent in several instances, he is allowed to participate in the program. Due to the tight market conditions which existed in many states, especially those with severe professional liability problems, the availability of insurance to physicians had been tenuous. Availability had been especially difficult for high risk specialties. Even when a physician found a carrier willing to insure him, there was little assurance that the physician would not be dropped at any succeeding renewal date.

Herbert Deneberg, State Commission of Insurance in Pennsylvania, in his testimony before the Secretary's Commission on Medical Malpractice states with regard to the crisis in Pennsylvania that: "In the 1960's, a shrinkingg malpractice market and skyrocketing premiums were apparent to everyone . . . The two immediate problems singled out for attention were the short-notice cancellations and nonrenewal activity by all companies . . ."[14] A graph accompanied this testimony listing a total of 689 cancellations and nonrenewals from July 1970 to September 1971. This situation is not unlike that of several other states.

The group program offers physicians the availability of coverage and also increases the prospects for continued availability. Even when certain members of a speciality group have splintered from the group plan in search of lower rates, the availability is there should they elect to return.

Essential to the determination of availability is the role executed by the group plan's peer review committee. Peer review of underwriting matters provides the physician recourse to an appeal process for any action taken by the carrier with regard to eligibility, nonrenewal, cancellation, claims settlement, or rate classification.

The peer review system developed by several group plans offers other advantages in addition to the underwriting function mentioned above. Peer review gives the physicians the benefit of expert analysis by his peers on the medical aspects of any claim brought against him. Without this medical judgement by his peers, the physician must weigh the decisions made by the carrier without recourse to other expert advice. Even though the physician often has to give his consent to settle a claim, there are numerous inferences that physicians believed they had been the victims of arbitrary decisions by the carrier. Peer review protects the physician from arbitrary decisions on defense of a case by the carrier.

Rating. It was not possible to determine from available data whether the benefit of lower rates is obtained by participation in a group plan. When a group plan is started or when a group plan under another carrier has terminated, some reduction of premiums is noted, e.g., a ten percent reduction by Argonaut in Florida, and a 22 percent reduction by the Hartford in Los Angeles. However, rate increases are the trend both for individual and group policies. For individual doctors who could only obtain coverage in the individual market by paying excess rates, the group plan usually offers coverage at standard rates. On the other hand, the practice of cream skimming has given numerous individual physicians coverage outside the group plan with lower rates. Although groups have generally lower rates than ISO's, any judgements concerning rates is group plans versus individual must be based on further research.

Some group plans offer rating features which, if realized, should produce savings for the insured. Premium refunds or dividends and return on investment income are all structured to produce savings for the insured. At this point,, however, these provisions have produced insignificant savings, if any. Another area where the physician may benefit is in the review undertaken by the society of rates and loss reserves. Many times this is done by a consulting actuary who provides a monitoring service of the carrier's rating and reserve techniques. It is interesting that in New York's plan where an actuary has been retained for several years, the retention factor is the lowest of the plans studied.

Claims handling and defense. Once a claim is made against a physician, the service benefits of a group plan are exercised. Specialized claims service and defense are often promoted as advantages of group plans. A group carrier, because of premium volume and number of insureds, is able to employ a specialized claims unit in geographical proximity to the group. Claims adjustors in this unit devote full-time investigating malpractice claims. A group carrier will also retain legal counsel specializing in professional liability defense. A physician obviously benefits by having experienced adjustors and attorneys service claims against him. However, it is not obvious that the service rendered through a group carrier is any better than that given through knowledgeable individual carriers.

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[14] U.S. Department of Health, Education, and Welfare, *Hearings*, before Secretary's Commission on Medical Malpractice, Washington, D.C., December 16, 1971, Statement B.

Disadvantages to insureds. Individual carriers may be able to offer less expensive professional liability coverage to physicians considered a good risk, i.e., those with a good loss experience in low-risk specialties. This occurs when the group rate structure subsidizes the higher risk specialists within the group. When group rates are structured to avoid "cream skimming," a potentially more severe problem arises. Such group plans are able to obtain a high participation rate and effectively preclude compeition from individual carriers. This situation leaves the group with the power to deny a physician the right to practice by denial of malpractice insurance. In short, the physician excluded by the group may have nowhere to go for his insurance coverage.

Advantages and disadvantages to insurers

Premium volume and rates. Society sponsorship of a group plan assures the carrier of a considerable market in terms of premium volume. This volume offers the carrier an ability to spread his risks over a wider base and increases his capacity to absorb higher losses. A large number of physicians insured under a group plan will also afford the carrier a wider base upon which to accumulate and analyze loss experience.

In attempting to secure a group plan, the carrier must be careful not to offer rating features which may weaken the stability of the plan. If rates are inadequate, refunds will never be realized, and the carrier will have to back down from its original offers, and this may weaken confidence of the insured physicians. If rates are very inadequate the insurer may be forced to raise rates substantially or even drop the plan.

Peer review. Although opinions are often expressed that peer review is an attempt to take decision-making away from the carrier on underwriting and claims matters, the peer review process can be a valuable source for the carrier. The carrier is able to obtain information relating to a physician which may otherwise not be available. It can also seek the opinion and advice of the peer review panel on claims incidents. Finally, the carrier has a vehicle which facilitates educating insured members to the trends and patterns of malpractice incidence. In addition, the peer review mechanism may minimize the physician's fears that the decisions of the carrier are arbitrary or not in his interest.

On the other hand, many carriers believe the peer review process hampers the carrier's ability to settle a case expeditiously and in the cheapest manner. The additional knowledge gained through the peer review process is insignificant in relation to the time and expense lost in the review. If the carrier disagrees with the recommendation of the committee on an individual claim, it leaves itself open for a dispute with the doctor who must in any event consent to any settlement.

Claims handling and defense. Large premium volume allows the carrier to develop specialized claims adjustors with expertise to investigate claims and render decisions on whether to settle or defend. Specialized defense counsel also provides the carrier with attorneys experienced in malpractice litigation who work closely with the claims adjustors and peer review committee to determine defensibility. A group plan with high participation will increase the likelihood that in a multiple defendant suit, all individual defendants will be insured by the group carrier. In these instances, defense counsel can present a unified defense and eliminate any disputes among defendants.

Advantages and disadvantages to patients. Peer review of claims has the objective of determining whether negligence occurred. Supposedly, if negligence is present in a case, the society and carrier believe the claimant should be compensated for his injury. Under these conditions, the more effective the peer review process is at judging medical negligence and the greater the extent the carrier is willing to work with this committee, the fairer the outcome for the patient. A disadvantage lies in the fact that the machinery built into group plans is basically for protection of the physician and not for protection of the patient. To the extent that group plans are successful in defending all claims they consider nonmeritorious, the initiation of claims will be discouraged. Plaintiffs' attorneys will be unwilling to pursue a claim especially where the injury is minor and the probable compensation is less than the cost of litigating the claim. In these instances, the control over which cases are to be compensated is largely held by the group carrier. This can increase the inequity which exists for those patients with valid though minor claims.

F. COMPETITION AMONG INSURERS

Competitive behavior, as distinct from monopolistic behavior, is a concept which is not easily measured or quantified. One of the problems is that perfectly competitive markets exhibit many of the same symptoms as perfectly monopolistic markets. For example, a uniform price for a good, no matter which firm produces it, is characteristic both of perfect competition and of price-fixing.

Since price levels and differences may be poor indicators of competition, economists have searched for substitute measures. These include the percent of a total market which is controlled by one, four, or ten firms. No one has decided what percent is "bad" or "good," but it does give some indication of market competition. Other measures are rates-of-return; the quality and quantity of information which flows to consumers; ease of entry into the industry; availability of the good to those consumers who are willing to pay the price; and dominance of one firm in selected regions. This section uses these measures to assess the competitiveness of the medical malpractice insurance market.

Market concentration

Using data obtained in Sub-Section C, it is possible to develop 1970 market concentration measures for medical malpractice insurers. Table III-11 indicates that the four largest insurers accounted for 28.1 to 50.8 percent of the total malpractice premium volume.[15] The ten largest insurers accounted for 47.8 to 86.2 percent. Neither of these lower figures is particularly high relative to other industries in the United States, and on this basis it would appear that medical malpractice insurance is sold in a competitive market. However, the higher figures are less comfortable.

TABLE III-11.

MEDICAL MALPRACTICE INSURANCE MARKET CONCENTRATION AS MEASURED BY PREMIUM VOLUME, 1970

Number of Firms	*Percent Market Controlled (by premium volume)*
#4	28.1 to 50.8%
10	47.8 to 86.2%

Source: Table III-6 and the Commission's survey of malpractice insurers. ("Medical Malpractice Insurance Claims Files Closed in 1970", *Supra,* p.00.)

Regrettably, adequate data were not available from all companies prior to 1970. It was therefore not possible to construct a meaningful time series of these concentration measures. With complete survey returns, it would be possible to remedy this situation.

Rate-of-return

Those insurers which were interviewed reported underwriting profits or losses ranging from +0.26 to -0.90 for the policy years 1960-1967. The distribution over the range was uniform, i.e., more insurers suffered underwritingg losses than profits.

Underwriting profits (losses) do not include returns on the investment reserves for losses incurred but not paid. Given the relatively long tail on medical malpractice loss payments, an insurer can suffer an underwriting loss yet make a profit. A profit can be made with a larger underwriting loss on malpractice than other lines of casualty insurance.

Given certain assumptions, it is possible to calculate the losses which an insurer can pay and still make a profit. This calculation is as follows:

1) PRofit = Premium —Losses — Expenses:

The typical underwriting profit, PR, is five percent of premium,

$$PR = .05P \ ,$$

and expenses are some fraction (e.g., 15, 27.5 or 40 percent) of premium: or

$$E = \alpha P.$$

Substituting these into (1) gives:

$$(2)\ L = (1 - \alpha - .05)P.$$

Investment income is:

$$I = \sum_{i=1}^{N} \left(\frac{r^{N+2-i} - r}{r - 1} \right) (L - \ell_i)$$

where r is the rate of interest, ℓ_i is the loss paid in year i, and N is the horizon of the loss tail. Through the payout period, it is necessary that total loss payments, Z, not exceed target losses plus investment income (L + I); or:

$$Z \leq L + I$$

substituting into (2) gives:

$$Z = (1 - \alpha - .05)P + I.$$

or

$$\frac{Z}{P} = (1 - \alpha - .05) + \frac{I}{P}$$

Table III-12 gives the ratio of the total loss payout which permits an underwriting profit equal to five percent of premium. The results are presented for interest rates, *r*, of .05, .06, and .07, and expenses equal to 15, 27.5, and 40 percent of premium. The loss distribution employed in the calculation of Table III-12 is displayed in Table III-13. This distribution is based on the 1960 policy year and is derived from limited survey returns. The distribution was adjusted slightly to include a possible shift to earlier loss payments.

TABLE III-12.

TOTAL LOSS PAYMENTS AS A RATIO TO PREMIUM VOLUME WITH UNDERWRITING PROFIT OF FIVE PERCENT

Interest Rate	Expenses as a Percent of Premium 15%	27.5%	40%
.04	0.936	0.790	0.644
.06	.958	.808	.659
.07	.978	.825	.672
Stipulated loss Ratio	.800	.675	.550

The final row of Table III-12 displays the loss ratio stipulated in the original rate-making. Thus, if 80 percent of the premium dollar was initially set aside for loss

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[15] The range is due to the difference in the premium volume estimate of NPA, $371 million, and the Commission, $205 million.

TABLE III-12a.

PROFIT INCLUDING INVESTMENT INCOME
AS A RATIO TO PREMIUM VOLUME
WITH AN UNDERWRITING PROFIT OF FIVE PERCENT

Interest Rate	Profit as a Fraction of Premium		
.05	.186	.165	.144
.06	.208	.188	.159
.07	.228	.200	.172
Stipulated loss ratio	.800	.675	.550

TABLE III-13.

AVERAGE DISTRIBUTION
OF LOSS PAYMENTS ON CLAIMS

Year	Percent Paid
One	3%
two	8%
three	22%
four	43%
five	61%
six	77%
seven	84%
eight	88%
nine	94%
ten	98%

Source: NPA's Survey of Medical Practice Insurers

payments and the interest rate is five percent, then total loss payments equal to 94 percent of the premium will permit a profit equal to five percent of premium. Stated otherwise, an apparent underwriting of nine percent will, when investment income is included, result in a profit of five percent or an underwriting profit of five percent will result in an actual profit of 18.6 percent with the inclusion of investment income (see Table III-12a). Inclusion of investment income does mitigate somewhat the previously mentioned poor underwriting profit experience of 1960-1967.[16]

Quantity and quality of consumer information

The discussion of Section IV indicates that practitioners and hospitals lack complete knowledge about the universe of malpractice insurers. This situation is not representative of a highly competitive market. However, the magnitude of this problem cannot be determined without an explicit survey of agents and insureds (see Section VI).

Ease of entry

Sub-Section L indicates that entry into the medical malpractice insurance field is limited by the "thin" malpractice reinsurance market. It seems impossible that a new malpractice insurer could be formed with the present reinsurance situation.

There are other means of entry into the malpractice market and the viability of each should enhance the level of competition. First, an established casualty writer can enter the malpractice market and obtain reinsurance. Second, malpractice insurers may expand their operations. Two-thirds of the companies interviewed stated that they had expanded malpractice activities.

Availability at any price

Sections IV and V indicate that malpractice insurance is generally available to qualified practitioners and institutions. There is an availability problem for those with a bad claims history. Carriers are reluctant to write a higher-than-normal risk unless it is through a group plan (see Sub-Section E). This reluctance indicates a certain lack of competition, or a certain number of incompetent health care providers, or a combination of both.

Regional dominance

The lack of dominance of a firm in the national market does not exclude a very restricted regional market. The advent of group plans has certainly made regional dominance more likely. A group plan with a high participation rate will drive individual carriers from the market.

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[16] Henry T. Kramer, a member of the Malpractice Commission who read the draft of this study, commented as follows:

Our company's conclusion is that loss payments equal to 98% of premium instead of 94% will produce a profit equal to 5% of premium; because accumulated investment equalled 18%, thus apparent underwriting loss of 13% will, when accumulated investment income is included, result in a profit of 5%. Both conclusions rest on a ten year period of claims development from 0-100% paid.

Neither the NPA's conclusion nor our company's can be considered as factual for even a moment insofar as its application to any specific portfolio of medical malpractice or any other kind of insurance business is concerned. Both rest on a number of specific assumptions which would never be the same for different cases.

However, to the extent that the "long tail" of claims permits a higher "permissible" loss ratio than a "short-tail," our analysis points to a somewhat higher permissible loss ratio than the analysis used by the NPA.

Translating either the NPA approach or ours into practical conclusions with respect to malpractice insurance is another matter. The credibility of initial loss reserves decreases as the tail of claims increases but it doesn's change in a straight-line manner. It becomes rapidly less credible as the tail lengthens. While the "expected" or anticipated *rate* of payments of claims over a ten year period as used by the NPA appears acceptable, I can say so only because the lack of data (to which a great deal of reference was made in the work of the Commission without full awareness of its application to this sensitive point) keeps me from saying otherwise.

In the real world, this effect probably works two ways. On the one hand, underwriters are loath to set permissible loss ratios using a 9-10 year anticipated development because it is so uncertain. On the other, investment income actually derived from reserves held over very long periods seems to have its attractions to cash flow analysts in a few carriers now seeking to write more business of this class.

All aspects of medical malpractice insurance induce a carrier to limit its operations to a few regions or similar states (in terms of malpracticce experience). Claims handling is most effective when left to specialists familiar with state laws and standards of care (see Sub-section K). Likewise, underwriting is easier (See Sub-section J). Most important, the quality of data increases markedly as area concentration increases.

There are steps (given in Section V) which can lessen the advantages from regional concentration, i.e., a national malpractice data bank, and minimize the possible abuses of regional concentration.

Summary

The market for medical malpractice insurance seems competitive in terms of market concentration and rates-of-return. However, the general scarcity of consumer information and reports of tie-in sales (see Appendix A) do raise doubts about the competitiveness of the market. The present degree of competition should be enhanced as the full dynamic effect of recent (1970-1972) rate increases is felt. The major constraint on competition arises from the advantages of regional concentration. These advantages can be minimized by following the recommendations of Section V, Sub-section A.

G. GEOGRAPHICAL DISTRIBUTION OF MEDICAL MALPRACTICE INSURANCE

This sub-section examines the geographical distribution of medical malpractice insurance in terms of premiums, incurred losses, and opened and closed claims, and the distribution pattern of general practitioners, surgeons, hospitals, and dentists throughout the United States.

This section is based on 1970 data obtained by the Medical Malpractice Commission. These data were obtained by using *Best's Insurance Reports* as well as informal sources of information to identify companies writing malpractice insurance. Approximately 80 companies were thus identified and sent mail questionnaires requesting data on premium income, incurred losses, claims opened and closed during 1970. As one of the purposes of the study was to obtain an idea of the geographic distribution of malpractice insurance, each company was asked to fill out a separate questionnaire for each state in which it was writing business.

Two limitations resulted from this study. First, the data were compiled from 31 respondents.[17]

Second, some of the companies treated two, three or more states as an administrative unit, and were unable to distinguished premium volume within individual states. As a result, the Medical Malpractice Commission had to do this on a somewhat arbitrary basis.

Distribution of insureds

As can be seen in Tables III-14, III-15, III-16, and III-17, 39 percent of all (nonfederal) general practitioners, 40 percent of the surgeons, 28 percent of the hospitals, and 41 percent of the dentists are located in the five most heavily populated states: California, Illinois, New York, Pennsylvania, and Ohio. According to 1970 Census data these states constituted about 36 percent of the country's total population. The percentages in these states manifest a comparatively greater concentration of physicians and dentists in relation to population than the rest of the nation.

In 12 other states[18] and the District of Columbia, the percentage of surgeons exceeds the percentage of general practitioners in each state. The states in this group tend to be moderately populated with urban concentrations. These states have 29 percent of the nation's surgeons and 24 percent of the nation's hospitals as compared to only 23 percent of the nation's general practitioners. They have 28 percent of the nation's dentists. Together these states account for approximately 20 percent of the total U.S. population. Thus these states also have more than their share of physicians and dentists.

A third group of 18 states[19], which are generally more rural and less populated than the second group, are relatively over-served by 19 percent of all general practitioners and 18 percent of all dentists for only 17 percent of the total U.S. population and are under-served by surgeons, 14 percent. It is interesting that these states have a greater share of the nation's hospitals, 24 percent—a possible reflection of the impact of the Hill-Burton Act.

The remaining 15 states[19a] and Puerto Rico are the most underserved areas in all categories with only 19 percent of the general practitioners, 17 percent of the surgeons, 24 percent of the hospitals, and only 13 percent of the dentists, serving 27 percent of the total population.

The percentage distributions for these four groups (I-IV, respectively) can be displayed in summary form as follows:

Group	Surgeons	General Practitioners	Hospitals	Denists	Population
I	40	39	28	41	36
II	29	23	24	28	20
III	14	19	·24	18	17
IV	17	19	24	13	27
	100	100	100	100	100

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[17] Seven other companies submitted data too late to be tabulated.

[18] Colorado, Connecticut, Florida, Georgia, Louisiana, Maryland, Massachusetts, Michigan, Missouri, New Jersey, Tennessee and Utah.

[19] Arizona, New Mexico, Oklahoma, Indiana, Iowa, Minnesota, Wisconsin, Idaho, Kansas, Montana, Nebraska, North Dakota, South Dakota, Alaska, Hawaii, Nevada, Oregon, and Washington.

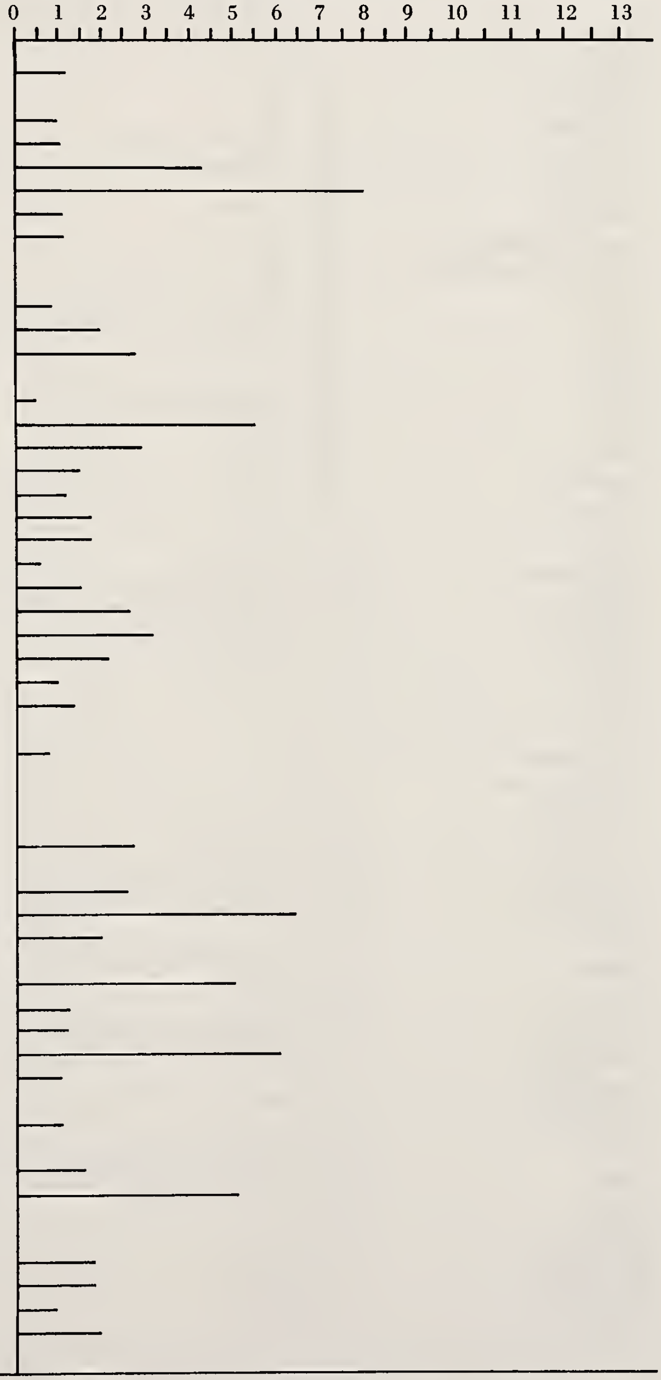
[19a] Alabama, Arkansas, Delaware, Kentucky, Maine, Mississippi, New Hampshire, North Carolina, Rhode Island, South Carolina, Texas, Vermont, Virginia, West Virginia and Wyoming.

TABLE III-14.

DISTRIBUTION OF (NONFEDERAL GENERAL PRACTITIONERS IN UNITED STATES AND POSSESSIONS BY RATING TERRITORY: 1970

(Total Number of Nonfederal General Practitioners in U.S. in 1970 = 54,938)

Rating Territory	Percentage of U.S. Total
Alabama	1.3
Alaska	.1
Arizona	.9
Arkansas	1.0
Los Angeles	4.3
California	8.3
Colorado	1.1
Connecticut	1.2
Delaware	.2
District of Columbia	.4
Dade and Broward, Florida	.7
Florida	2.0
Georgia	1.6
Hawaii	.4
Idaho	.5
Illinois	5.6
Indiana	3.0
Iowa	1.6
Kansas	1.2
Kentucky	1.6
Louisiana	1.6
Maine	.5
Maryland	1.5
Massachusetts	2.6
Michigan	3.3
Minnesota	2.2
Mississippi	1.1
Missouri	1.6
Montana	.4
Nebraska	.9
Nevada	.3
New Hampshire	.4
Bergen, New Jersey	.3
New Jersey	2.8
New Mexico	.4
New York City	2.8
New York	6.5
North Carolina	2.0
North Dakota	.3
Ohio	5.0
Oklahoma	1.2
Oregon	1.2
Pennsylvania	6.3
Puerto Rico	1.0
Rhode Island	.4
South Carolina	1.2
South Dakota	.4
Tennessee	1.6
Texas	5.3
Utah	.5
Vermont	.2
Virginia	2.0
Washington	2.0
West Virginia	.8
Wisconsin	2.2
Wyoming	.2



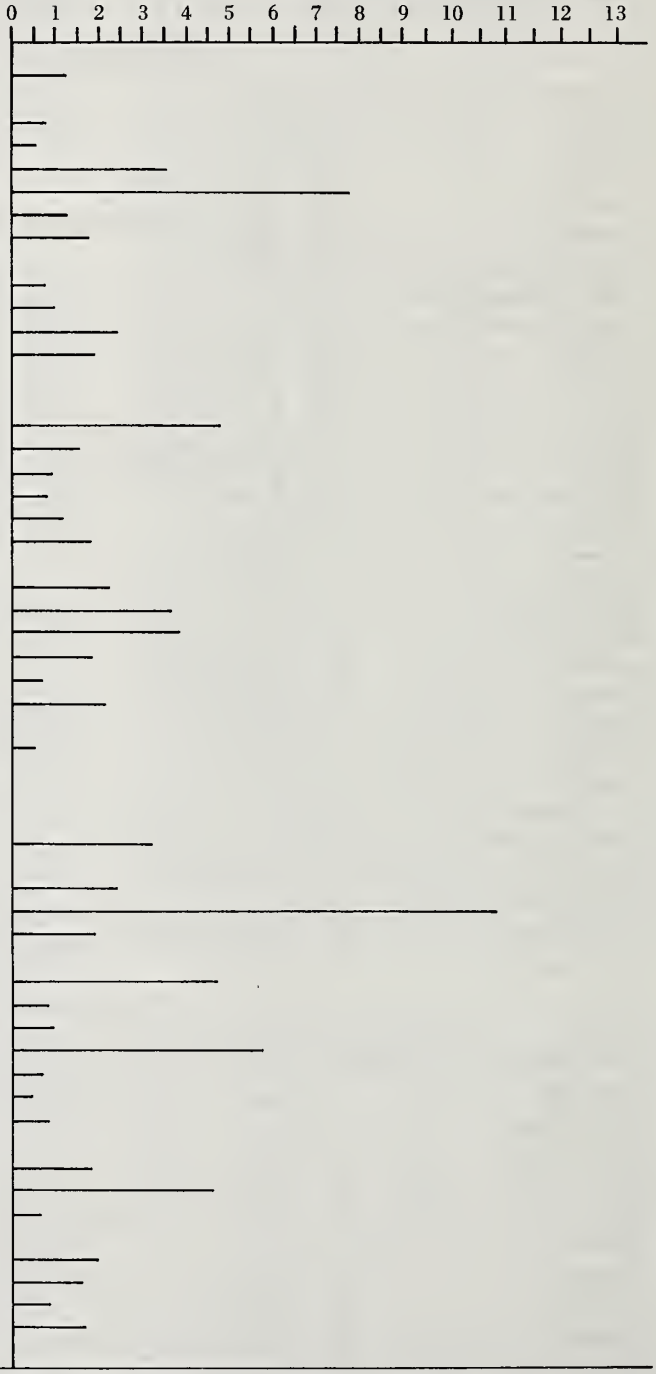
Source: American Medical Association, center for Health Services, Research and Development, *Distribution of Physicians in the United States, 1970,* Table 9, pp. 72-126.

TABLE III-15.

DISTRIBUTION OF (NONFEDERAL SURGEONS IN UNITED STATES BY RATING TERRITORY 1970

(Total Number of Nonfederal Surgeons in U.S. in 1970 = 79,326)

Rating Territory	Percentage of U.S. Total
Alabama	1.2
Alaska	.1
Arizona	.8
Arkansas	.5
Los Angeles	3.6
California	7.8
Colorado	1.3
Connecticut	1.8
Delaware	.2
District of Columbia	.9
Dade and Broward, Florida	1.0
Florida	2.5
Georgia	1.9
Hawaii	.4
Idaho	.2
Illinois	4.9
Indiana	1.6
Iowa	1.0
Kansas	.8
Kentucky	1.2
Louisiana	1.8
Maine	.4
Maryland	2.4
Massachusetts	3.7
Michigan	3.9
Minnesota	1.8
Mississippi	.7
Missouri	2.2
Montana	.3
Nebraska	.5
Nevada	.2
New Hampshire	.3
Bergen, New Jersey	.3
New Jersey	3.2
New Mexico	.4
New York City	2.5
New York	10.9
North Carolina	2.0
North Dakota	.2
Ohio	4.8
Oklahoma	.9
Oregon	1.1
Pennsylvania	5.8
Puerto Rico	.7
Rhode Island	.5
South Carolina	.9
South Dakota	.2
Tennessee	1.9
Texas	4.6
Utah	.6
Vermont	.2
Virginia	1.9
Washington	1.6
West Virginia	.7
Wisconsin	1.7
Wyoming	.1



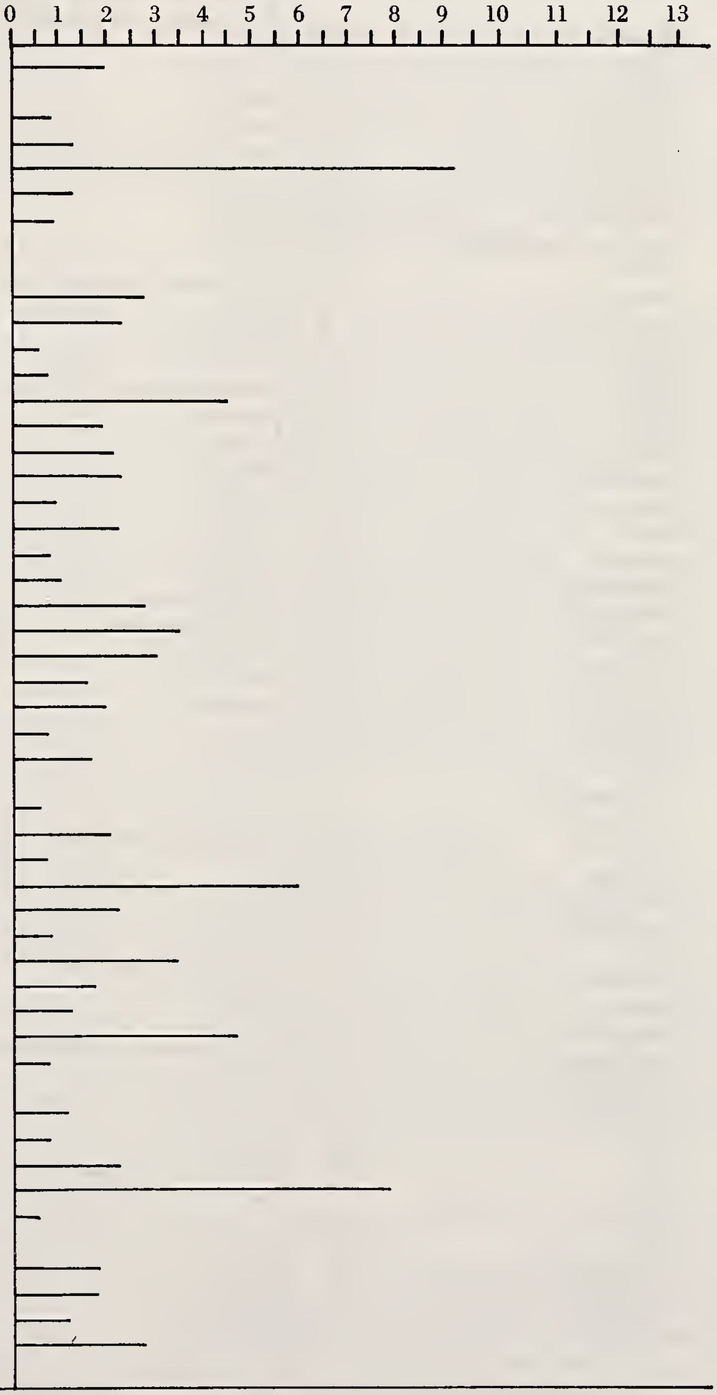
Source: American Medical Association, Center for Health Services Research and Development, *Distribution of Physicians in the United States, 1970,* Table 76-126.

TABLE III-16.

DISTRIBUTION OF NONFEDERAL HOSPITALS IN UNITED STATES 1970 BY STATE

(Total Number of Nonfederal Hospitals in U.S. in 1970 = 6,715)

State	Percentage of U.S. Total
Alabama	1.9
Alaska	.2
Arizona	.9
Arkansas	1.4
California	9.1
Colorado	1.3
Connecticut	.9
Delaware	.2
District of Columbia	.3
Florida	2.7
Georgia	2.3
Hawaii	.5
Idaho	.8
Illinois	4.5
Indiana	1.9
Iowa	2.1
Kansas	2.3
Kentucky	1.9
Louisiana	2.1
Maine	.8
Maryland	1.1
Massachusetts	2.9
Michigan	3.5
Minnesota	3.0
Mississippi	1.5
Missouri	2.0
Montana	.9
Nebraska	1.6
Nevada	.3
New Hampshire	.5
New Jersey	2.0
New Mexico	.7
New York	6.0
North Carolina	2.3
North Dakota	.9
Ohio	3.5
Oklahoma	1.9
Oregon	1.4
Pennsylvania	4.6
Puerto Rico	.8
Rhode Island	.3
South Carolina	1.2
South Dakota	.8
Tennessee	2.3
Texas	7.8
Utah	.5
Vermont	.4
Virginia	1.8
Washington	1.8
West Virginia	1.2
Wisconsin	2.9
Wyoming	.4



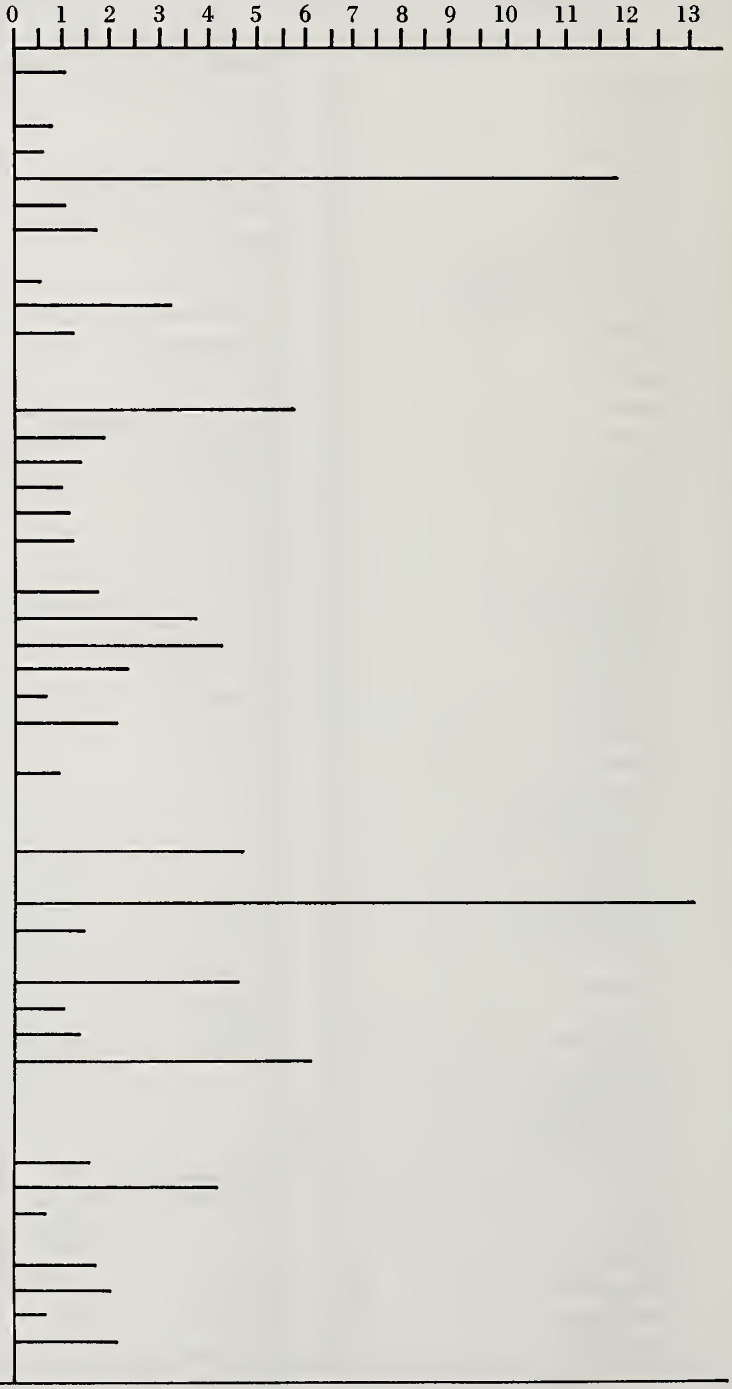
Source: Journal of the American Hospital Association, *Hospitals*, August 1, 1971, Table 3, pp. 468-479.

TABLE III-17.

DISTRIBUTION OF NONFEDERAL DENTISTS IN 1970 BY STATE

(Total Number of Nonfederal Dentists in U.S. in 1970 = 112,879)

State	Percentage of U.S. Total
Alabama	1.0
Alaska	.1
Arizona	.8
Arkansas	.6
California	11.9
Colorado	1.2
Connecticut	1.8
Delaware	.2
District of Columbia	.6
Florida	3.3
Georgia	1.4
Hawaii	.4
Idaho	.3
Illinois	5.7
Indiana	2.0
Iowa	1.4
Kansas	1.0
Kentucky	1.1
Louisiana	1.3
Maine	.4
Maryland	1.7
Massachusetts	3.6
Michigan	4.2
Minnesota	2.4
Mississippi	.6
Missouri	2.1
Montana	.3
Nebraska	.9
Nevada	.2
New Hampshire	.3
New Jersey	4.8
New Mexico	.3
New York	13.2
North Carolina	1.5
North Dakota	.2
Ohio	4.6
Oklahoma	.9
Oregon	1.4
Pennsylvania	6.0
Rhode Island	.4
South Carolina	.2
South Dakota	.3
Tennessee	1.5
Texas	4.2
Utah	.6
Vermont	.2
Virginia	1.7
Washington	2.0
West Virginia	.6
Wisconsin	2.3
Wyoming	.1



Source: American Dental Association, Bureau of Economic Research and Statistics, *Facts About States*, 1971, p.6.

Distribution of the market

The five most heavily populated states, California, Illinois, New York, Pennsylvania, and Ohio, which accounted for 39 percent of the country's general practitioners and 40 percent of the surgeons, accounted for 49 percent of the total malpractice premium income (see Table III-18). Almost half the premium income from this group was generated in California, which had approximately twice as many general practitioners and surgeons as any of the other states except New York.

It is interesting to note that premium income from New York is about half the premium income from California, although the percentage of general practitioners in California is only 3.3 percent higher than that in New York, and the percentage of surgeons in New York is actually higher by 2 percent. This would seem to indicate that doctors in California are paying considerably more for malpractice insurance.

Column 2 of Table III-18 indicates that the five most heavily populated states accounted for 54 percent of losses incurred in 1970. While the percentage of incurred losses in California, Ohio, Illinois, and Pennsylvania was roughly the same as percentage of premium income, New York's percentage of incurred losses was almost double the percentage of premium income. This may reflect lower expenses, other than losses, in New York.

These five states accounted for 47 percent of the claims closed in 1970, and 54 percent of the claims opened during that year. While 19 percent of the claims closed were in California, approximately half of the 51 percent opened during 1970 were in that state; a reflection on the favorable legal climate in that state and an increasing propensity of California residents to litigation.

The second group of 12 states and the District of Columbia paid 25 percent of the total malpractice premium insurance in 1970. Together, these states accounted for 25 percent of the incurred losses during 1970. In only four of the states–District of Columbia, Georgia, Maryland, and New Jersey–did the percentage of incurred losses exceed that of premiums. In the District of Columbia and Maryland, the percentage of incurred losses was over twice that of premium income. This same group accounted for 27 percent of the claims opened during 1970 and only 21 percent of the claims closed during that year.

Premium income in the third group of 18 states was 15 percent of the total, while incurred losses were only 13 percent. In total, this category accounted for 14 percent of the claims closed during 1970, and only 9 percent of the claims opened during this year.

The remaining group of 15 states accounted for 11 percent of the premium income and only 8 percent of the losses. This group also had a relatively high percent of closed claims, 18 percent, with just 10 percent of claims still open. Not surprisingly, the areas which are the most underserved have the least malpractice activity.

The percentages distributions for these four categories are displayed by state group as follows:

Group	Premium Income	Losses Incurred	Closed Claims	Claims files opened
I	49	54	47	54
II	25	25	21	27
III	15	13	14	9
IV	11	8	18	10
	100	100	100	100

In conclusion, it seems that urbanization and legal climates in the various states appear more important in determining malpractice insurance rates than the actual breakdown of general practitioners and surgeons.

H. ACTUARIAL PRACTICES IN PHYSICIANS' AND SURGEONS' PROFESSIONAL LIABILITY INSURANCE[20]

The actuarial practices in connection with physicians' and surgeons' professional liability insurance are relatively simple in comparison with practices employed in some other lines of insurance. This relatively simple approach to ratemaking results primarily from two factors. First, the total premium volume for physicians' and surgeons' professional liability insurance insurance does not exceed 2.5 percent of the total property-liability insurance premium volume and may be somewhat less. The relatively small premium volume does not provide an adequate statistical basis for sophisticated actuarial techniques. Also, there is very little incentive to develop sophisticated techniques for handling a line which represents such a small part of total income. Second, it appears that no single insurer, or rating bureau, has statistical data for more than one-third of the market. This further division of an already small market prevents the development of more analytical ratemaking techniques.

Insurance Services Office

The ratemaking techniques of the Insurance Services Office (ISO) will be used to illustrate current practices. Differences in the techniques used by individual insurers will be indicated in later sections of this report.

Professional liability insurance rates for basic limits coverage are calculated by ISO on the basis of past premium and loss experience within the state in which the rate will be used. Basic limits, at the present time, are $5,000 of coverage for each claim or suit and $15,000 of

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[20] Due to the lack of readily available data in other areas this section, prepared by Professor Bernard L. Webb of Georgia State University, is limited to physicians and surgeons. Much of the description and many of the conclusions apply to hospitals, dentists, etc.

Table III-18. DISTRIBUTION OF TOTAL MALPRACTICE INSURANCE PREMIUM INCOME, INCURRED LOSSES, CLOSED CLAIMS AND CLAIMS FILES OPENED BY STATE, 1970

State	Percentage of U.S. Total			
	Premium Income	Incurred[1] Losses	Closed Claims	Claims Files Opened
Alabama	.9	.6	.7	.7
Alaska	*	*	*	*
Arizona	1.2	1.3	1.5	1.4
Arkansas	.5	.4	.5	.5
California	23.1	22.2	18.9	24.6
Colorado	1.5	1.2	1.7	1.6
Connecticut	1.7	.6	1.2	1.1
Delaware	*	*	*	*
District of Columbia	.6	1.3	1.1	.4
Florida	2.4	1.7	3.2	3.2
Georgia	1.1	1.5	1.2	.5
Hawaii	.2	.2	.2	.1
Idaho	.2	*	.2	.3
Illinois	4.5	3.8	6.5	6.3
Indiana	1.8	1.3	1.8	1.7
Iowa	1.2	.9	1.0	.8
Kansas	.7	.5	.9	.8
Kentucky	1.1	.5	.9	.8
Lousiana	1.2	.8	1.3	1.0
Maine	.3	.1	.2	.3
Maryland	1.2	2.8	2.0	1.5
Massachusetts	2.1	1.8	1.9	1.3
Michigan	5.4	3.6	4.5	4.7
Minnesota	1.5	1.4	2.5	1.3
Mississippi	.3	.2	.5	.2
Missouri	1.8	.8	1.9	1.8
Montana	.4	.1	.4	.4
Nebraska	.5	.6	.6	.4
Nevada	.4	.2	.4	.5
New Hampshire	.2	.1	.4	.4
New Jersey	5.0	7.9	4.9	5.3
New Mexico	.4	.6	.4	.3
New York	11.8	20.4	12.1	12.8
North Carolina	.6	.4	.7	.7
North Dakota	.1	.2	.2	.1
Ohio	4.9	3.6	3.9	3.8
Oklahoma	.4	1.0	.9	.2
Oregon	.6	.6	1.0	.6
Pennsylvania	4.4	3.8	5.6	6.0
Puerto Rico	.1	*	*	*
Rhode Island	.2	.1	.2	.2
South Carolina	.3	.1	.4	.1
South Dakota	.2	.3	.2	.1
Tennessee	1.0	.7	1.4	1.9
Texas	3.7	2.4	2.8	3.5
Utah	.3	.2	.3	.2
Vermont	.1	.1	.2	.1
Virginia	.9	1.4	.1	.3
Washington	3.4	1.7	3.1	3.0
West Virginia	.4	.4	.4	.5
Wisconsin	1.6	1.8	1.9	1.4
Wyoming	.1	.1	*	.1

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[1] Includes loss and loss expenses attributed to claims closed during 1970.

* Less than .1

Source: Medical Malpractice Commission Closed Claims Study, 1970, "Summary Activity of all Reporting Companies."

coverage for all claims and suits during the policy period. These limits frequently are written as $5/15,000. On January 1, 1973, basic limits will be increased to $25/75,000.

Coverage is not written for amounts less than basic limits. However, higher limits can be obtained. The premium for higher limits is determined by multiplying the basic limits premium by an increased limits factor. For example, under present ISO rules the premium for limits of $100/300,000 for a surgeon is found by multiplying the basic limits premium by 3.78. The comparable multiplier for a physician is 2.99. The excess limits factors were determined on the basis of national experience and are not revised as frequently as basic limits rates.

The average rate increase for a given state is determined by comparing the adjusted actual loss ratio for the state to the loss ratio which was contemplated in the current rates. A loss ratio is the ratio of the dollar amount of losses (see next paragraph) to the dollar amount of premiums. Before the loss ratio is calculated for ratemaking purposes adjustments are made to both the losses and the premiums. The premiums used in calculating the loss ratio are determined by multiplying the number of earned exposure units (e.g., the number of physicians and surgeons insured) by the present basic limits rates. This procedure eliminates the distortions which might result from rate changes during the experience period if actual collected premiums were used. Also, the actual collected premiums would include excess limits charges.

The losses which go into the loss ratio formula are adjusted using a loss development factor. This factor is a multiplier which is intended to reflect the extent to which the insurers have overestimated or underestimated the amount which they will pay out on claims. It is based on an analysis of the accuracy of estimates in the past. The ISO currently uses a loss development factor based on an analysis of the development of losses for the policy years 1960 and 1970. These data show that insurers have consistently underestimated their claim liabilities in connection with physicians' and surgeons' professional liability during that period. Consequently, the amount of losses, as reported by insurers, has been increased. The increase ranges from 3.4 percent for policy year 1966 losses, to 200.7 percent for policy year 1970. The smaller increase for 1966 losses reflects the fact that a larger percentage of that year's losses have been settled, leaving less margin for error in estimation.

The losses, which include allocated loss adjustment expenses, also are increased to include unallocated loss adjustment expenses. Allocated loss adjustment expenses are those expenses which are clearly associated with the handling of a particular claim, such as fees for attorneys and expert witnesses. Unallocated loss adjustment expenses are those loss adjustment expenses which are not associated with a particular claim, such as salaries of company claims personnel and the expense of maintaining company claims offices.

The weighted average loss ratio for the latest two policy years is used for ratemaking purposes. The weighted average is calculated by multiplying the loss ratio for the latest policy year by .70, the loss ratio for the last previous policy year by .30 and adding the two products. The weighted average loss ratio is then multiplied by a trend factor to adjust for the inflationary trend in the average amount of a single claim. The trend factor is determined by fitting a least squares regression line to the average claim amounts for the past five years, and using the resulting formula to project the change to the midpoint of the period for which the new rates will apply. Recent rate filings by ISO have shown a trend factor of 1.242 before the adjustment for Federal price control regulations, but rates were calculated using a factor of 1.199 after adjustment for price control regulations.

The rate adjustment factor is determined by dividing the actual loss ratio, after the adjustments discussed above, by the expected loss ratio as provided by the ratemaking formula. A recent ISO rate filing in Pennsylvania showed an expected loss ratio of 62.5 percent. That is, the sum of losses and loss adjustment expenses was expected to equal 62.5 percent of premiums. An ISO filing in Arizona showed an expected loss ratio of 56 percent. The difference between the two expected loss ratios resulted from a difference in the expense loading formula in the two states. Pennsylvania rates included an allowance of 15 percent of premiums for commissions and brokerage, while 21.5 percent of premiums was allowed for that expense item in Arizona.

The composition of the expense loading in the Pennsylvania rate filing was as follows:

General Administration and Inspection	.110
Other Acquisition Expense	.035
Underwriting Profit and Contingency	.050
Taxes, Licenses and Fees	.030
Commissions and Brokerage	.150
Total	.375

The ISO divides physicians and surgeons in private practice into five classes for ratemaking purposes. Separate classifications are maintained for physicians and surgeons active in U.S. military service, and for those active in Federal employment other than military. The relationship between the rates for the five principal classifications are:

Class 1	100%
Class 2	175%
Class 3	300%
Class 4	400%
Class 5	500%

These relationships are determined on the basis of national statistics and judgement, rather than the state statistics which are used for the calculation of basic limits rates.

Although ISO uses only five classifications for ratemaking purposes, statistical data are coded by 18 classifications. Thus, further refinement of the rating classification system is possible within the present statistical plan.

Other insurers

Some of the major underwriters of physicians' and surgeons' professional liability insurance are not affiliated with ISO, and do not report statistics to ISO or use ISO rates. A few insurers which are affiliated with ISO do not report all of their statistics to ISO, and do not use ISO rates in all cases. For example, some ISO affiliated companies do not report statistics to ISO for policies written under group-sponsored plans written in cooperation with state medical societies, but do report statistics to ISO and use ISO rates for other policies.

Those companies which do not use ISO rates employ techniques which differ somewhat from ISO procedures. For example, one major carrier calculates its rates based on the premiums and losses for the total limits purchased, rather than basic limits as used by ISO. Virtually all of this carrier's professional liability premiums are derived from a group plan for the medical society of a single state. The use of total limits premiums and losses might be more acceptable for it than for ISO, which must develop rates for each state. Another carrier uses basic limits of $100/300,000 in lieu of the ISO basic limits of $5/15,000 ($25/75,000 after January 1, 1973).

The ISO uses only one trend factor, based on the change over time in the average paid claim amount. One independent carrier uses two trend factors, one reflecting changes in the average claim amount and the other reflecting changes in the frequency of claims. Two insurers use a trend factor based on changes in the pure premium. The pure premium is the portion allocated for the payment of claims and claim expenses. It is calculated by dividing the dollar amount of claims, after multiplication by the development factor, by the number of doctors insured during the period. A trend factor based on the pure premium is equivalent to the use of separate trend factors for loss amount and loss frequency.

It is interesting to note, however, that ISO's average paid claim amount as used in calculating trend factors is substantially lower than that of Employers' Insurance of Wausau. The ISO average claim amount is for basic limits coverage of $5/15,000, while the Employers' average claim amount is for total limits. The ISO average paid claim amount for 1970 on basic limits of $5/15,000 and exclusive of New York, was $2,030, while Employers' reported an average paid claim, on total limits and in New York, of $13,272. In 1971, ISO's average loss increased to $2,077 while Employers' dropped to $10,112. It seems likely that the ISO figure includes other lines of professional liability, as well as coverage for physicians and surgeons. The ISO average *incurred claim for total limits* in 1970 for physicians and surgeons was $26,800. These figures are a further indication of the variations in the professional liability exposure, and in the statistical data available from various sources.

The Medical Society of the State of New York has seven rating classifications of physicians and surgeons and territories. However, statistical data are coded separately for thirty-six specialties and for each county. The ratio of the premium for the highest rated specialty to that for the lowest rated specialty in the same territory is approximately 18 to one, as opposed to five to one for the ISO rates. The ratio of the highest rate for the state to the lowest rate for the state, considering both specialty and territory, is approximately 40 to one. The rates thus reflect to a much greater degree the risk variation among medical specialties.

Some other rating refinements are used in connection with group sponsored professional liability plans written for medical organizations. The Florida Medical Association will use a merit rating plan. Under that plan the premium will be increased for a doctor who has had a claim made against him under the policy, provided a peer review committee of his county medical association decided that he was at fault in the incident.

Several insurers have group-sponsored plans under which they agree to credit to the sponsoring association a portion of the investment income earned on the reserves for losses which have been incurred but not paid. Such investment income can amount to a substantial sum, since there may be a long delay between the date of occurrence of the event and the date of payment of the resulting claim. The actuary for Employers' Insurance of Wausau has testified that, on the average, claims against that company under physicians' and surgeons' professional liability coverage are paid out approximately as follows:

Year Reported and Evaluated	Cumulative Percent Paid	Percent Paid During Year
First year	1%	1%
Second year	6%	5%
Third year	16%	10%
Fourth year	31%	15%
Fifth year	45%	14%
Sixth year	61%	16%
Seventh year	72%	11%
Eighth year	80%	8%
Ninth year	94%	14%
Tenth year	95%	1%

Five percent of the dollar amount of claims for the year 1962 were still outstanding in 1971. An official of another company has estimated that the investment income from a mature book of professional liability insurance will equal approximately 15% of premiums.

Several insurers have group-sponsored plans under which they have agreed to refund to the sponsoring organizations, or its participating members, the excess of loss reserves over the amounts actually needed to settle losses. Practices differ as to the disposition of such refunds. Some carriers make such refunds to the current participants in the plan, while others try to make the refund to the physicians who were participating in the plan at the time the loss event occurred. It is apparent that, because of the long delay in loss settlement, there may be substantial changes in the membership of the sponsoring organization before all losses are settled. One insurer prefers to make such refunds to a charitable organization, possibly a foundation sponsored by the medical society. This carrier maintains that delivering such refunds to present participants is not equitable, since many of the present participants did not participate when the fund was created. Delivery to the participants who created the fund may be impossible (e.g., deceased members), or very difficult (e.g., retired members who cannot be located).

Statistical problems

One of the major problems which hampers competition in the field of physicians' and surgeons' professional liability insurance is the lack of readily available statistical data. The only central agency for the collection of such data at the present time is Insurance Services Office, a rating bureau and advisory organization owned and operated by its member and subscriber insurers. Several of the major underwriters of professional liability insurance are not members or subscribers to ISO. Some insurers which are members or subscribers to ISO do not report all of their statistical data to ISO. For example, companies which write group plans do not report the plan's premium and losses for their plans to ISO while they do report premiums and losses for some of their other professional liability business.

Some state medical organizations retain consulting actuaries. It is possible that such associations may be able to provide competing insurers with adequate data to permit a competitive market for their plans. However, a central source for the collection of data under a standard statistical plan would be more conductive to a competitive market.

The availability of more complete statistical data also would facilitate the development of more sophisticated actuarial techniques. It would be possible to devise rating classification systems which more equitably reflect the differences in loss exposures among the various medical specialties, among individuals within the specialties, and among rating territories.

The ISO also lacks the authority and the facilities to make meaningful quality checks on the data furnished to it by insurers. A recently developed computerized editing system will detect many of the more obvious errors, which can be found by testing for internal consistency on the data. However, it is doubtful that such a system can detect all significant errors. Such a program might, for example, detect an error if an insurer reports the proper exposures but erroneous premiums. It seems unlikely that it could detect an error in which an insurer erroneously omitted both the exposures and the premiums, or reported both twice. The detection of such errors would require an on-sight reconciliation of the insurer's statistical report against its basic records.

The potential for such errors was demonstrated by a recent ISO filing for an increase in hospital professional insurance rates in New Jersey. An investigation by state insurance regulatory authorities revealed many errors in the ISO supporting data. One hospital for which ISO showed an annual premium of $931 had actually paid a premium of $8,871. Officials of ISO have indicated that the corrected data indicated a higher rate increase than that called for by the incorrect data. However, the incident does indicate that the possibility for incorrect data does exist.

I. MEDICAL MALPRACTICE INSURANCE RATES

The statement that professional liability (medical malpractice) rates have been increased since 1960 cannot be questioned. There is some ambiguity as to what institutions and specialties and which states have experienced the most rapid increases, and how these rate increases compare with increases in the general price level, the cost of medical services, and the income of practitioners. The appropriate time profiles and comparisons are developed in the second part of this subsection. The first part will summarize the typical process of determining medical malpractice rates.

Determining medical malpractice rates

Malpractice rates are generally computed in a two-step procedure. First, there is a rate dependent on the type of institution or medical practice for the basic limits of a policy. Next, there are expansion factors for higher limits of coverage which when multiplied by the basic rate give the premium for the high coverage.

In general, the first step in determining malpractice rates is to analyze the national or state[21] loss experience by class of hospital or practitioner. For hospitals, the typical classifications include clinics, nursing homes, hospitals, psychopathic hospitals, and sanitariums. Doctors are generally classified by specialty and the amount of surgery they perform. The analysis by class may show, for example, that one class of physicians has five times the loss experience of another class. Table III-19 summarizes the class differences for practitioners in the years 1966 through 1972. As can be seen the differentials have remained stable since the first year ISO used the five classification system.

The class definitions are [ISO (1972)]:

Class 1.	Physicians who do not perform or ordinarily assist in surgery;
Class 2.	Physicians who perform minor surgery or assist in major surgery on their own patients;
Class 3.	Physicians who perform major surgery or assist with major surgery on patients other than their own, i.e., opthalmologists and proctologists;
Class 4.	General surgeons and others, i.e., cardiac surgeons, urologists, etc.;
Class 5.	Surgeons who specialize in anesthesiology, orthopedics, etc.

Basic limits

Basic limits are usually described as $5/15,000, $25/75,000, or $100/300,000. The number on the left of the slash (/) is the limit (of dollars in thousands) per occurrence of a malpractice incident. The number on the right of the slash is the limit of coverage for all occurrences within the year the policy is in effect (or the policy year). For example, $5/15,000 coverage implies that the insurance company will pay an individual claim up to $5,000 and will pay up to $15,000 in claims during a policy year.

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[21] ISO uses national loss experience while some companies look at state loss experience when their state market penetration is high. See sub-section H for a complete description of the actuarial techniques.

Increased limits

Increased limits refer to any standard policy which has insurance limits greater than the basic limits. As shown in Table III-20, in 1972 a class 1 or 2 physician would pay 2.99 times the basic rate for $100/300,000 coverage while surgeons (classes 3, 4, and 5) and hospitals would pay 3.78 times the basic rate. Prior to 1970 all physicians and hospitals had the same increased limits.

Some companies that do not use ISO rates have different increased limits tables either because of different experience, different basic limits, or different pooling of extraordinary losses. However, the trend in the ISO factors should be a fair representation of the trend experienced in the industry.

Excess limits

Although the increased limits table is defined to limits of $3,000/9,000,000, most companies do not write a single policy that large. Typically, a practitioner will get a basic policy for limits of $100/300,000, or $200/600,000 with hospitals receiving limts in the same to higher range. If a practitioner or hospital desires greater (excess) coverage, a rider is attached to the basic policy, or a separate policy is issued for the excess.

The excess coverage generally takes one of two forms. One is simply an increase in the level of professional liability coverage to $1,000/3,000,000 (say). The other form is an umbrella policy which insures against all liability up to some specified limit. The excess may be written by the same carrier or a different carrier which specializes in excess coverage.

Individual rating and higher-than-normal risks

The preceding sub-section summarized the rates facing the typical practitioner or hospital. However, hospitals are often rated individually for the combination of their professional and premise liability. This practice permits the insurer to survey the hospital's facilities and incorporate the hospital's malpractice and general liability experience.

Also, the combination coverage eliminates the problem of determining whether a claim is malpractice or general liability. The result is a tremendous spread of possible rates which make the derivation of a "standard" malpractice rate difficult and obscures the actual volume of hospital malpractice premiums and losses.

Some practitioners who have had a history of malpractice losses find that the only coverage available to them is at a higher-than-normal rate. This rate may be determined through peer review in group plans, the rate charged by Lloyds of London, or the rate charged by a surplus carrier. "Regular" insurers seldom quote a higher-than-normal rate for an individual practitioner unless he is part of a group plan.

Table III-19 THE RATIO OF THE BASE RATE FOR CLASS TWO, THREE, FOUR, AND FIVE PHYSICIANS AND SURGEONS TO THE BASE RATE FOR CLASS ONE PHYSICIANS, 1960-1972

	Class				
Year	1	2	3	4	5
1966	1.00	1.25	2.38	3.57	n.a.
1967	1.00	1.75	3.03	4.00	5.00
1968	1.00	1.75	3.03	4.00	5.00
1969	1.00	1.75	3.03	4.00	5.00
1970	1.00	1.75	3.03	4.00	5.00
1971	1.00	1.75	3.03	4.00	5.00
1972	1.00	1.75	3.03	4.00	5.00

There are exceptions to these ratios, most notably, New York City (1969-1972). However, they are correct for most rating territories in most years.

Source: ISO (1966-1972).

Consent-to-rate. When an institution or practitioner is quoted a rate which deviates from the rate approved by the state insurance commissioner,[22] it is necessary to obtain the insurance commissioner's consent. A consent-to-rate application is made. The application is on an individual basis where the institution or practitioner agrees to the rate quoted by the company.

Surplus carrier. The consent-to-rate process is quite feasible for an institution as the institution's premium is large enough to justify the insurer's time. Also, the size and engineering complexity of hospitals makes individual rating necessary (and probably desirable) for many hospitals. However, the number of practitioners and their generally lower premium levels hinders the consent-to-rate mechanism at a practitioner level. Also, it is more feasible for an insurer to evaluate correctly a hospital's engineering than to evaluate the quality of medicine practiced by an individual practitioner. If insurers could evaluate the quality of a practitioner, the insurer would still be faced with the impossible task of policing the practitioner's work and "bringing it in line" with accepted norms. All of these constraints make surplus carriers of Lloyds[23] the only alternative for some high risks. As a surplus carrier specializes in high risks, it does not have "regular" rates on

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[22] Approval of insurance rates is not required in all states; e.g., California.

[23] Some comment has been made that Lloyds is less receptive to writing medical malpractice insurance as Lloyds has a difficult time determining rates and adjusting claims. If this is true for Lloyds, it could be true for surplus carriers. These developments could have a severe impact on the availability of insurance for marginal practitioners with a history of medical malpractice claims.

Table III-20. PHYSICIANS', SURGEONS', DENTISTS', AND HOSPITALS' INCREASED LIMITS TABLE FOR PROFESSIONAL LIABILITY INSURANCE *

Limits of Liability	Physicians, Surgeons, Dentists and Hospitals		Dentists and Class 1 and 2 Physicians	Hospitals and Surgeons
	1960-68	1969	1970-72	1970-72
5/15	1.00	1.00	1.00	1.00
10/30	1.35	1.53	1.66	1.93
15/45	1.55	1.83	2.04	2.45
20/60	1.64	1.96	2.20	2.68
25/75	1.71	2.07	2.34	2.87
30/90	1.77	2.16	2.45	3.03
50/150	1.89	2.34	2.68	3.35
100/300	2.06	2.59	2.99	3.78
200/600	2.19	2.79	3.24	4.13
250/750	2.23	2.85	3.31	4.24
500/1500	2.36	3.04	3.55	4.57
1000/3000	2.57	3.26	3.95	5.13
1500/4500	2.72	3.58	4.23	5.52
2000/6000	2.83	3.75	4.44	5.81
2500/7500	2.92	3.88	4.60	6.04
3000/9000	2.99	3.99	4.74	6.23

* The increased limits were separated between dentists, class 1 and 2 physicians, and hospitals and surgeons in November, 1969.

Source: ISO (1960-1972).

file with the state insurance commissioner. The institution or hospital simply enters into an insuring agreement with the surplus carrier and the process effectively circumvents the regulation mechanism.

Surcharges for high risks. The time constraints of the study did not permit a full investigation of the magnitude of the surcharges applied to higher-than-normal risks. These surcharges may take the form of deductibles (for those experiencing high frequency/low severity), rate surcharges, or a combination of both. The deductibles are limited to the amount paid to the claimant, and are not applied to defense costs. The magnitude of the rate surcharges may range up to ten times the normal rate. Both of these approaches are discussed in the case studies of group malpractice insurance plans.

Medical malpractice insurance rates and rate indices

There are many problems with comparing medical malpractice insurance rates over time. The most prominent include which company's or organization's malpractice rates should be used as a base. Second, when comparing premium levels between 1960 and 1972 what limits of coverage should be employed. Comparing the premiums for the same limits would not be appropriate in more than a decade of claims growing in frequency and severity. (See Sub-section C). Also, what weights should be employed in deriving a national medical malpractice insurance cost index. Fourth, which price deflator should be used to put premium costs in constant dollar terms. As the approach taken for practitioners and hospitals differed in various respects the next two parts will consider each in turn.

Medical malpractice insurance rates for practitioners

The “proper“ set of rates selected as a base for both practitioners and hospitals is that promulgated by ISO. There are certainly numerous exceptions to these rates. These exceptions arise in states (-rating territories) with group plans, or in states where an individual writer has enough insureds to “make” its own rates, or because insurers have different cost factors than those used by ISO.

The latter exception is most dramatic for those insurers who are direct writers and pay their representatives a salary plus little or no commission. Also, all insurers are at greater liberty to compete in terms of the acquisition, production, and overhead cost of policy (loss expenses are, in a sense, determined by the extent of medical malpractice, the laws of tort, and the behavior of juries). The result is a degree of variability in the percent of the premium allocated to these expenses by the insurers. Table III-21 compares the cost factors applied by ISO to the ranges of those applied by the larger medical malpractice insurers. The lower factors which some insurers apply to the "manageable" costs imply that the malpractice insurance rates charged by these insurers will be less than ISO's.[24]

TABLE III-21. COST FACTORS AND EXPENSE EXPERIENCE OF ISO COMPARED TO ALL MEDICAL MALPRACTICE INSURERS

Expense Category	Factors	
	ISO	Range Reported by Medical Malpractice Insurers
Acquisition/Production	.25	.05 to .20
Administrative/ General Overhead	.12	.05 to .12
Miscellaneous	.03	.03 to .05
Underwriting Profit	.05	.05
Loss Adjustment and Losses	.55	.55 to .86

Source: ISO and NPA survey of insurers.

However, ISO rates will be used as the basis for an index because their rates accurately represent the trend in medical malpractice insurance premiums, even though ISO's rates may overstate the absolute magnitude. Also derivation of any price index is not trivial. It is necessary to have at least a semi-uniform base in order to construct a meaningful index.

Limits of liability. Comparing premium costs between 1960 and 1972 requires determination of the limits of liability which afford the insured the same degree of protection in 1972 as in 1960. Obviously a $100/300,000 policy in 1972 would not afford the same degree of protection as a $100/300,000 policy in 1960. The degree of protection is defined as the percent of the malpractice loss distribution for which the insurer assumes liability when the insured buys the policy.

A "true" malpractice rate index could be derived by first observing the distribution of medical malpractice losses in each year. Then one could assume that the insured bought a policy to cover some fixed segment (95.0 percent) of this distribution; e.g., a policy whose limits are such that 95.0 percent of all losses are less than those limits. Yearly limits derived in this manner would define the premium necessary to have bought constant degree of coverage.

The major obstacle of this approach is a lack of data on the yearly loss distribution (see Section V). To circumvent this problem, it was assumed that the insurance rates reflected an accurate representation of the loss distribution. There are drawbacks to this assumption. In particular, medical malpractice insurance rates are infamous for their inadequacies during the late 1960's. However, the necessary assumption is that the changes in increased limits (see Table III-20) is a representation of the shift over time in the actual loss distribution. Given this assumption, the derivation of a rate index can be exemplified as follows.

When a physician buys insurance, he is effectively selling a good (his malpractice risk) for a negative price (the premium payment). The distribution of malpractice losses can be represented by a function, F(L), where L is the loss. The distribution is also a function of time (the reason why constructing the index is a problem). A sequence of these distributions, $F_t(L)$, is given in Figure III-1. These distributions have been shifting downward over time; i.e., the probability of incurring any loss has increased, the expected loss has increased, and the probability of incurring a loss less than any value has decreased.

The optimal situation for an insurance company is to buy enough of these distributions to permit the law of large numbers to drive the actual loss experience equal to the expected loss. By obtaining enough individual distributions, the insurance company can charge a premium equal to the expected loss plus a fee. The large number property reflected in insurance rates permits us to ignore risk and risk aversion in the construction of the rate indices.

Figure III-2 represents a sequence of distribution functions for malpractice losses over three time periods. Given that there are policy limits, and that there is some probability (no matter how small) of a loss greater than the limits, the doctor can only sell a piece of his malpractice loss distribution. For the sake of simplicity, suppose he decides to sell all but the last five percent of this distribution, i.e., he sells up to the 95 percent line in Figure III-2.

As given in Figure III-2, 95 percent of the expected malpractice loss will fall to the left of L_1 in the first period, L_2 in the second, and L_3 in the third. The premium for each distribution is:

$$\int_0^{L_{t_\ell}} dF_t\,(L) = P_t$$

the expected loss over the interval $[0, L_t]$, plus a fee.

To estimate the F_t (L) functions, the best available data are the increased limits exhibited in Table III-20. Each set of factors approaches a limit as the coverage increases. Second, ignoring the base rates for the present, the factors should trace a curve, on the limit per claim—factor space, that represents (except for a scale problem) the loss distribution function.[25]

The estimating procedure assumes that the factors may be written as an exponential function of the limits, as:

$$F = A - B \exp\,[-\beta L]$$

where F is the expansion factor and L is the limit per occurrence. The parameters to be estimated are A, the limit of F, B, and β for each of the four columns in Table

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[24] The investigation of rates uncovered only one state where this relationship is in doubt—Pennsylvania in 1972. However, this case is due to the ISO filing its new rates after enactment of the wage-price freeze.

[25] If the curve did not make such a representation, one would need to conclude that ISO and the insurance companies were irrational.

FIGURE III-1

PROBABILITY THAT AN INDIVIDUAL PRACTITIONER
WILL INCUR LOSS OF ANY SPECIFIED AMOUNT

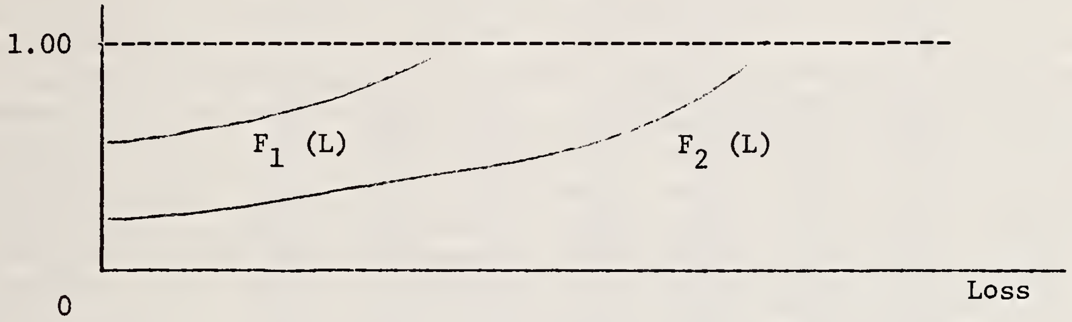
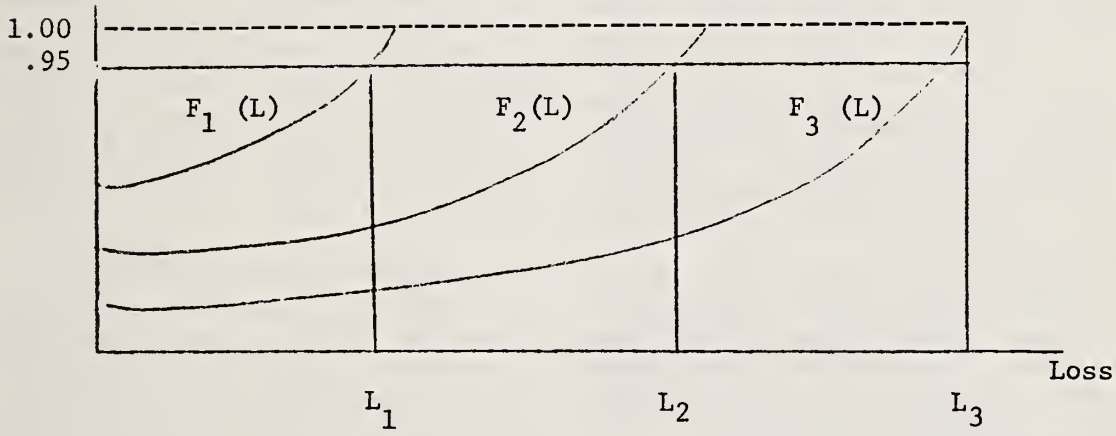


FIGURE III-2

PROBABILITY THAT AN INDIVIDUAL PRACTITIONER
WILL INCUR LOSS OF ANY SPECIFIED AMOUNT AT
THREE SUBSEQUENT TIMES



III-20. The nonlinear estimation gave limits of 3.04, 4.07, 4.84, and 6.37, respectively.[26]

As a $100/300,000 policy in 1960 had an expansion factor of 2.06, the appropriate expansion factor for 1969 was computed as:

$$\frac{F}{4.07} = \frac{2.06}{3.04};$$

for physicians in 1970-72,

$$\frac{F}{4.84} = \frac{2.06}{3.04};$$

and for surgeons in 1970-72,

$$\frac{F}{6.23} = \frac{2.06}{3.04};$$

The resulting expansion factors were 2.76, 3.28, and 4.32, respectively. These factors corresponded to insurance limits of $184/522,000; $228/674,000; and $442/1,326,000. In other words a surgeon who had $100/300,000 coverage in 1960 would need $442/1,326,000 coverage in 1972.

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[26] The fit of the regressions was good in each case (R^2 = .96) and all of the parameters were significant. The regression results are available upon request.

Weights employed to derive the national index. As the relative base rates have remained constant between the various classes of practitioners since 1967 (see Table III-19), only classes 2 and 4 were employed directly in the derivation of the rate index. Two classes were necessary because of the divergence in expansion factors in 1970. Also, class 2 physicians seem typical of those practitioners who do not do a great deal of surgery, and class 4 is the middle class for the surgical specialties.

The premium is calculated for a $100/300,000 policy in the years 1960-1968; $184/552,000 in 1969; $228/674,000 in 1970-1972 for class 2; and $442/1,320,000 in 1970-1972 for class 4. The calculation gives the cost of a constant degree of coverage by rating territory. Next, the ratio of general practitioners in each territory to the total in the U.S. (see Sub-section G) is multiplied by the territory's premium. The sum of these products is the weighted average cost of a medical malpractice policy which offers the same degree of coverage over the years 1960-1972. The weighted average premium was obtained for class 4 by using the ratio of surgical specialists in a territory to the national total.

Tables III-22 and III-23 present the time profile of rates by rating territory relative to the national rate. For example, the entries for California in Table III-22 indicate the malpractice premium for class 2 has always been more than twice the national average. Also, the increase in the ratios over time indicates that California rates have grown faster than the national average. For example, the average cost of malpractice coverage increased from $233 (2.103 x $110.7) in 1960 to $1,598 (2.575 x $620.5) in 1970. Tables III-24 gives the national average for class 2 and class 4, in dollars, as an index, and as a percent of the average income of practitioners.

Medical malpractice rates for dentists. As the expansion factors for dentists have remained constant since 1960, it was only necessary to derive the cost of a 100/300 policy by rating territory. The weighted sum of these premiums was calculated, and an index constructed as exhibited in Table III-25. Table III-26 gives the relative cost of malpractice coverage by rating territory.

Medical malpractice insurance rates for hospitals

Due to time constraints, the analysis of the medical malpractice insurance rates for hospitals was based on the years 1960, 1966, 1970, and 1972. Initially, the institution classes selected for examination were profit and non-profit hospitals with surgical facilities. With few exceptions, the rates for these two classes of hospitals are identical.[27] Thus, the investigation was limited to for-profit hospitals with surgical facilities.

The per bed rates for $5/15,000 coverage for each of the rating territories is represented as a ratio to a base rate (Connecticut's) in Table III-27. Rates for hospitals are determined jointly by the rate per bed and the rate per 100 outpatient visits. However, the rate per 100 outpatient visits is ten percent of the per bed rate, and for display purposes its inclusion offers no additional insights.

National weighted average per bed rates. The derivation of a hospital medical malpractice insurance rate index differed slightly from the derivation of the practitioner's index. The ratio of non-federal hospitals in each territory to total non-federal hospitals (see Sub-section G) was multiplied by the territory's per bed rate and weight sum obtained for 1960, 1966, 1970, and 1972. The result is displayed in Table III-27, along with the relative bed rates by rating territory.

The "average" hospital. For insurance purposes, the number of hospital beds is defined as the daily average number of beds, cribs, and bassinets used for patients. Per hospital, the national average daily beds in use and number of yearly 100 outpatients is applied to the average national rates to obtain the average medical malpractice premium cost for $5/15,000.

Increased limits. Not many hospitals would find $5/15,000 coverage adequate. As the increased limits table for hospitals is identical to that of surgeons, premiums for $100/300,000 in 1960 and 1966 and $442/1,326,000 in 1970 and 1972 give the dollar cost of a constant degree of coverage. The average national cost of this coverage is displayed in column 1 of Table III-28. The second column converts these figures into an index, and the third column presents the price index for all medical services.

J. UNDERWRITING PRACTICES

Underwriting practices differ significantly between the individual and group markets. In the individual market underwriting emphasis is on selectivity, whereas in a group plan the carrier typically foregoes much of this selectivity and agrees to write virtually every member who applies for the group insurance. Because underwriting in the two markets is so different, the individual and group markets will be discussed separately.

Underwriting individual risks

In a sense, underwriting selection begins at the point where actuarial classifications stop. As the two previous sections have shown, actuaries use available statistical information to classify individual hospitals or practitioners into different premium categories based upon past losses and exposure to risk.[28] An actuary may calculate that on

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[27] The exceptions in 1972 included North Carolina where the non-profit rate is $10 per bed versus the for-profit rate of $16; South Carolina, $2.50 versus $10; and Virginia, $5 versus $13.50. These exceptions are generally due to various charitable immunity restrictions. As these restrictions are falling, the for-profit seems a better example for the purposes of this study.

[28] As indicated in Subsection H of this section, actuarily established premium differentials can vary widely, as between companies or actuaries. ISO rate categories use a 5:1 ratio between the highest and lowest rated categories, whereas in the New York State Group plan the high/low ratio is 18:1.

Table III-22. PHYSICIANS: THE RELATIVE COST OF CONSTANT LEVEL OF MEDICAL MALPRACTICE COVERAGE FOR THE VARIOUS ISO RATING AREAS, 1960-1972.
(National Average = 100)

Rating Territory	Year 1960	1962	1964	1966	1968	1970	1971	1972
Alabama	63.3	61.0	54.2	46.8	59.5	45.5	107.4	99.6
Alaska	134.0	129.1	114.6	100.3	79.3	76.7	107.4	99.6
Arizona	96.8	93.3	97.6	108.4	176.7	135.3	130.0	138.5
Arkansas	61.4	77.1	68.1	65.6	53.7	82.5	71.9	66.7
Los Angeles	210.3	202.6	190.5	-	-	-	-	-
California	210.3	202.6	224.5	226.1	267.5	257.5	247.1	252.2
Colorado	91.2	87.9	79.0	85.6	121.4	116.8	101.9	121.8
Connecticut	54.0	52.0	58.8	54.9	69.4	77.7	78.4	86.8
Delaware	46.5	44.8	44.9	44.2	66.9	57.6	50.3	46.6
District of Columbia	130.3	125.5	125.4	141.8	105.7	67.7	92.4	85.7
Dade and Broward, Florida	102.4	100.4	89.8	77.6	159.4	152.8	133.2	123.6
Florida	-	-	-	133.8	94.1	90.9	79.3	73.5
Georgia	81.9	95.0	83.6	72.3	73.5	61.3	74.2	77.8
Hawaii	70.7	68.1	58.8	107.0	107.3	43.2	116.2	107.7
Idaho	89.4	86.1	74.3	70.9	82.6	52.9	64.5	77.8
Illinois	89.4	86.1	75.9	78.9	56.1	65.6	86.2	80.0
Indiana	70.7	75.3	85.2	80.3	57.8	57.6	59.9	55.6
Iowa	96.8	80.7	79.0	84.3	90.0	57.6	54.9	65.8
Kansas	55.8	69.9	77.4	77.6	61.7	52.9	78.4	72.7
Kentucky	113.5	109.4	100.7	87.0	59.5	66.6	58.1	53.9
Louisiana	72.6	80.7	71.2	61.5	61.9	93.6	81.6	75.7
Maine	91.2	87.9	85.2	73.6	52.0	40.7	35.5	44.0
Maryland	91.2	75.3	68.1	58.9	52.0	51.8	45.2	41.9
Massachusetts	78.2	75.3	85.2	95.0	69.4	44.4	38.7	38.5
Michigan	83.8	105.8	94.5	99.9	85.0	141.7	123.5	133.8
Minnesota	100.5	96.8	85.2	73.6	60.3	71.4	62.2	100.9
Mississippi	104.2	80.7	60.4	52.2	36.3	37.0	32.3	52.6
Missouri	80.0	84.3	68.1	66.9	56.1	59.2	51.6	64.6
Montana	96.8	93.3	89.8	77.6	66.9	101.0	102.5	95.1
Nebraska	46.5	44.8	44.4	48.2	34.7	47.1	71.9	66.7
Nevada	134.0	129.1	144.0	160.6	117.2	135.3	118.0	163.7
New Hampshire	52.1	64.6	71.2	61.5	40.5	23.3	20.3	18.8
Bergen, New Jersey	111.7	107.6	162.6	171.3	150.3	120.5	105.1	97.5
New Jersey	65.2	62.8	97.6	100.3	123.0	120.5	105.1	97.5
New Mexico	111.78	107.69	97.6	108.4	94.1	96.2	126.0	128.7
New York City	158.3	141.7	159.5	137.8	173.4	190.3	214.8	199.2
New York	93.1	89.7	116.1	100.3	101.6	93.0	104.6	97.1
North Carolina	54.0	52.0	46.5	40.1	38.0	32.3	28.1	34.6
North Dakota	85.6	82.5	71.2	72.3	52.0	37.0	32.3	44.9
Ohio	78.2	82.5	74.3	70.9	56.1	94.6	94.5	100.9
Oklahoma	100.5	121.9	106.9	92.3	86.7	91.5	79.8	74.0
Oregon	156.4	150.6	137.8	153.9	134.6	73.0	79.8	74.0
Pennsylvania	52.1	64.6	68.1	65.6	71.0	64.0	55.8	51.7
Puerto Rico	72.6	69.9	63.5	60.2	55.3	64.0	55.8	51.7
Rhode Island	48.4	55.6	51.1	57.5	49.5	34.4	30.0	27.8
South Carolina	65.2	53.8	48.0	41.5	33.1	28.6	24.9	23.1
South Dakota	85.6	82.5	71.2	72.3	50.4	39.1	49.3	45.7
Tennessee	104.2	125.5	110.0	95.0	75.1	52.9	46.1	42.8
Texas	55.8	69.9	61.9	64.2	57.8	55.5	48.4	44.9
Utah	87.5	68.1	60.4	65.6	61.1	85.1	111.6	103.5
Vermont	46.5	44.8	40.3	38.8	27.3	35.4	30.9	28.6
Virginia	83.8	64.6	63.5	54.9	49.5	50.2	57.2	53.0
Washington	121.0	139.9	123.9	128.4	94.1	90.9	99.1	91.9
West Virginia	50.3	48.4	44.9	46.8	36.3	52.9	80.7	74.8
Wisconsin	124.7	107.6	85.2	73.6	61.9	60.3	65.5	60.7
Wyoming	48.4	46.6	44.9	41.5	33.2	37.0	32.3	29.9
U.S. Average (in dollars)	$110.7	$114.9	$133.0	$154.0	$250.0	$620.5	$711.5	$767.2

Table III-23. SURGEONS: THE RELATIVE COST OF CONSTANT LEVEL OF MEDICAL MALPRACTICE COVERAGE FOR THE VARIOUS ISO RATING AREAS, 1960-1972.
(National Average = 100)

	Year							
Rating Territory	1960	1962	1964	1966	1968	1970	1971	1972
Alabama	73.7	60.5	55.0	47.4	59.2	45.0	109.7	99.5
Alaska	155.5	127.7	115.5	99.6	79.4	76.2	109.7	99.5
Arizona	112.4	92.3	98.1	109.9	176.1	134.0	132.8	138.4
Arkansas	71.0	76.0	68.7	65.8	53.4	81.7	73.4	66.6
Los Angeles	243.7	200.0	192.3	-	-	-	-	-
California	243.7	200.0	227.8	282.3	267.0	255.2	252.3	252.2
Colorado	106.1	87.1	80.6	86.4	121.2	115.7	103.9	122.0
Connecticut	62.9	51.7	58.8	55.9	69.3	77.1	80.0	86.8
Delaware	54.0	44.3	45.2	44.2	66.4	56.9	51.1	46.4
District of Columbia	151.5	124.0	127.5	143.7	105.3	67.0	90.7	82.3
Dade and Broward, Florida	120.5	98.9	90.5	78.0	158.7	151.5	136.1	123.5
Florida	-	-	-	107.1	93.8	90.0	80.8	73.3
Georgia	95.3	93.7	84.5	72.8	73.6	60.6	75.9	77.8
Hawaii	81.8	67.2	49.6	108.0	106.8	66.1	118.7	107.8
Idaho	103.4	84.9	74.7	70.9	54.8	52.3	66.0	77.8
Illinois	103.4	84.9	76.3	79.4	56.3	65.2	88.2	80.1
Indiana	81.8	74.5	82.3	81.3	57.7	56.9	61.0	55.4
Iowa	112.4	79.7	80.6	84.6	89.5	56.9	56.1	65.9
Kansas	64.7	69.4	76.8	78.0	62.1	52.3	80.0	72.6
Kentucky	96.2	79.0	74.7	64.4	59.2	66.1	59.4	53.9
Louisiana	84.5	79.7	72.5	62.5	77.9	92.7	83.3	75.6
Maine	106.1	87.1	86.1	74.2	52.0	40.4	36.3	44.2
Maryland	106.1	74.5	68.7	59.2	520	51.4	46.2	41.9
Massachusetts	90.8	74.5	82.3	96.3	69.3	44.1	39.6	35.9
Michigan	97.1	104.8	95.9	99.6	85.1	140.5	126.2	134.0
Minnesota	116.9	96.0	86.1	74.2	67.8	70.7	63.5	101.1
Mississippi	120.5	79.7	61.0	52.6	36.1	36.7	33.0	52.4
Missouri	92.6	83.4	68.7	67.6	56.3	58.8	52.8	64.4
Montana	112.4	92.3	90.5	78.0	66.4	100.1	103.1	93.5
Nebraska	54.0	44.3	43.0	48.9	34.6	46.8	73.4	66.6
Nevada	155.5	127.7	141.1	162.5	116.9	134.0	120.4	163.9
New Hampshire	60.2	63.5	70.3	60.6	40.4	23.0	20.6	18.7
Bergen, New Jersey	94.4	106.3	152.6	172.4	150.1	119.3	107.2	97.3
New Jersey	54.8	62.0	89.9	101.5	122.7	119.3	107.2	97.3
New Mexico	129.5	106.3	98.1	109.9	93.8	95.5	128.6	128.7
New York City	139.4	167.2	161.3	139.1	173.2	206.6	234.8	213.1
New York	89.9	110.7	117.7	101.5	101.0	101.0	90.7	104.0
North Carolina	61.1	50.2	46.9	40.4	37.5	32.1	28.9	34.4
North Dakota	98.9	81.2	72.5	72.8	52.0	36.7	33.0	44.9
Ohio	90.8	81.2	74.7	70.9	56.3	93.6	96.5	101.0
Oklahoma	116.9	120.3	107.9	93.0	86.6	90.9	81.6	74.1
Oregon	181.6	149.1	139.5	155.5	134.2	72.5	81.6	74.1
Pennsylvania	60.2	63.5	68.7	65.8	70.7	63.3	56.9	51.6
Puerto Rico	84.5	69.4	64.8	61.1	54.8	63.3	56.9	51.6
Rhode Island	55.7	54.6	51.2	57.3	49.1	34.0	30.5	27.7
South Carolina	75.5	53.1	49.0	42.3	33.1	28.5	25.6	23.2
South Dakota	98.9	81.2	72.5	72.8	50.5	38.6	50.3	45.7
Tennessee	120.5	124.0	111.7	96.3	75.0	52.0	47.0	42.7
Texas	64.7	69.4	62.7	64.4	57.7	55.1	49.5	44.9
Utah	101.5	67.2	61.0	65.8	60.6	84.0	85.3	77.4
Vermont	54.0	44.3	41.4	39.0	27.4	34.9	31.3	28.4
Virginia	116.9	76.8	64.8	55.9	49.1	49.6	58.6	53.1
Washington	88.1	86.4	78.5	67.6	93.8	90.0	101.4	92.1
West Virginia	58.4	48.0	45.2	47.4	36.1	52.3	82.5	74.8
Wisconsin	144.8	106.3	86.1	74.2	62.1	59.7	66.8	60.6
Wyoming	55.7	45.8	45.2	42.3	33.2	36.7	33.0	29.9
U.S.Average (in dollars)	$229.1	$279.1	$378.1	$438.5	$571.0	$1880.9	$2094.0	$2307.4

Table III-24. NATIONAL PRICE AND INDEX FOR PHYSICIANS' AND SURGEONS' MALPRACTICE INSURANCE, 1960-1972

	Physicians (Class 2)			Surgeons (Class 4)		
Year	Dollar Cost	Index (1966=100)	Premium as Percent of income[1]	Dollar Cost	Index (1966=100)	Premium as Percent of income[2]
1960	110.7	71.9	NA	229.1	52.3	NA
1962	114.9	74.6	0.5%	279.1	63.7	NA
1964	133.0	86.4	0.5	378.1	86.2	1.2%
1966	154.0	100.0	0.6	438.5	100.0	1.2
1968	249.5	162.1	0.8	571.0	130.2	1.4
1970	620.5	403.0	1.8	1,880.9	428.9	4.2
1971	711.5	462.1	NA	2,094.0	477.5	NA
1972	767.2	498.3	NA	2,307.4	526.2	NA

[1] The income figure used is for self-employed general practitioners, Copyright ©1972 by Medical Economics Company, Oradell, New Jersey 07649

[2] The income figure used is for self-employed general surgeons; also from *Medical Economics.*

Table III-25. NATIONAL PRICE AND INDEX FOR DENTISTS' MALPRACTICE INSURANCE, 1960-1972

Year	Dollar Cost	Index (1966=100)
1960	$66.1	82.2
1962	69.4	86.4
1964	69.6	86.6
1966	80.4	100.0
1968	84.0	104.5
1970	114.1	142.0
1971	123.4	153.6
1972	123.4	153.6

Source: ISO Rating Manual

average the loss exposure or risk associated with an anesthesiologist is five times greater than that for a general practitioner who never performs any surgery. A similar statement holds true for territorial classifications, i.e., an anesthesiologist in California pays five and one-half times the premium of his counterpart in Texas due to statistically measurable differences in losses between the two states. (Regional rate differentials will reflect different legal doctrines or statutes, general litigiousness of the population and a variety of other factors which may vary between states or regions within a state.)

The challenge to underwriting individual risks is that all anesthesiologists do not constitute the same exposure to risk, even though actuaries are unable to statistically measure the exposure presented by each individual anesthesiologist. The job of the underwriter is to decline to write those individuals who, for one reason or another, constitute higher-than-average risks within their actuarial classification. Some companies attempt to write all normal (or better-than-normal) risks, and select out only those who appear to be worse-than-normal. A few highly selective companies attempt to take only those risks considered to be better-than-average.

The most widely used criterion for determining a worse-than-normal risk is previous non-defensible claims. If the applicant is a physician, carriers also ascertain the hospital(s) where he has staff privileges, and whether the hospital is certified by the Join Committee on Accreditation of Hospitals (JCAH). Whether any carriers attempt to distinguish between the many JCAH-certified hospitals is not known, although some knowledgeable observers stated that substantial differencces exist and that the hospital, even though JCAH certified, is a significant factor in the carrier's exposure to loss.[29] Underwriting criteria appear to be somewhat subjective. Those companies who attempt to be more highly selective use various means for attempting to differentiate risks. Following are examples of underwriting critiera used by one or more carriers:

- Require every anesthesiologist to fill out an additional detailed form with questions pertinent only to his specialty (screening of applicants is then based on answers to these questions);

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[29] Carriers underwriting individual risks usually ask where a physician attended medical school and where he completed his internship. What use is made of this information is not known. Application for group plans do not request this information.

Table III-26. DENTISTS: THE RELATIVE COST OF CONSTANT LEVEL OF MEDICAL MALPRACTICE COVERAGE FOR THE VARIOUS ISO RATING AREAS, 1960-1972.
(National Average = 100)

	Year			
Rating Territory	1960(13.50)	1966(16.00)	1970(25)	1972(29.00)
Alabama	100.0	100.0	76.0	55.2
Alaska	100.0	100.0	76.0	172.4
Arizona	100.0	100.0	76.0	103.5
Arkansas	100.0	100.0	76.0	75.9
California	203.7	218.8	400.0	344.8
Colorado	100.0	100.0	88.0	103.5
Connecticut	100.0	100.0	100.0	100.0
Delaware	100.0	100.0	88.0	75.9
District of Columbia	166.7	187.5	180.0	203.5
Florida	100.0	125.0	160.0	137.9
Georgia	100.0	100.0	76.0	134.5
Hawaii	NA	NA	NA	NA
Idaho	100.0	100.0	88.0	75.9
Illinois	74.1	84.4	76.0	79.3
Indiana	100.0	100.0	88.0	131.0
Iowa	92.6	84.4	72.0	100.0
Kansas	100.0	100.0	70.0	60.4
Kentucky	74.1	62.5	40.0	75.9
Louisiana	96.3	100.0	80.0	110.4
Maine	100.0	100.0	88.0	100.0
Maryland	100.0	100.0	76.0	86.2
Massachusetts	74.1	62.5	76.0	82.8
Michigan	100.0	100.0	120.0	155.2
Minnesota	100.0	100.0	96.0	75.9
Mississippi	100.0	84.4	54.0	46.6
Missouri	74.1	62.5	88.0	131.0
Montana	100.0	100.0	88.0	151.7
Nebraska	100.0	100.0	88.0	100.0
Nevada	100.0	100.0	88.0	75.9
New Hampshire	100.0	100.0	74.0	63.8
New Jersey	111.1	118.8	76.0	96.6
New Mexico	100.0	100.0	76.0	65.5
New York City	133.3	168.8	116.0	179.3
New York	111.1	103.1	84.0	127.6
North Carolina	100.0	100.0	64.0	55.2
North Dakota	100.0	100.0	88.0	100.0
Ohio	100.0	100.0	96.0	103.5
Oklahoma	100.0	100.0	88.0	86.2
Oregon	74.1	62.5	88.0	106.9
Pennsylvania	74.1	62.5	60.0	51.7
Puerto Rico	100.0	100.0	100.0	86.2
Rhode Island	74.1	62.5	40.0	34.5
South Carolina	74.1	62.5	40.0	34.5
South Dakota	100.0	100.0	76.0	65.5
Tennessee	100.0	100.0	76.0	65.5
Texas	NA	NA	NA	NA
Utah	100.0	100.0	88.0	113.8
Vermont	100.0	100.0	76.0	65.5
Virginia	100.0	84.4	54.0	46.6
Washington	100.0	109.4	180.0	155.2
West Virginia	100.0	84.4	56.0	48.3
Wisconsin	100.0	62.5	40.0	34.5
Wyoming	100.0	100.0	64.0	65.5
U.S. Average in Dollars	$14.6	$17.2	$26.3	$38.7

Table III-27. RELATIVE PER BED RATES FOR HOSPITAL PROFESSIONAL LIABILITY INSURANCE BY RATING TERRITORY, 1960, 1966, 1972
(Connecticut=100)

	Year							
Rating Territory	1960	1962	1964	1966	1968	1970	1971	1972
Alabama	62.4	59.3	59.2	51.3	36.8	45.1	25.0	(same as 1971)
Alaska	62.4	59.3	59.2	51.3	36.8	27.1	25.0	
Arizona	118.5	112.7	112.5	128.2	122.7	81.2	75.1	
Arkansas	46.8	44.5	44.4	38.5	36.8	45.1	41.7	
Los Angeles	218.2	207.7	207.3	–	–	–	–	
California	218.2	207.7	207.3	256.4	245.3	270.8	263.8	
Colorado	93.5	89.0	88.8	64.1	61.3	63.2	75.1	
Connecticut	93.5	89.0	106.6	92.3	88.3	65.0	90.2	
Delaware	46.8	44.5	44.4	76.9	73.6	81.2	75.1	
District of Columbia	171.5	163.2	162.9	141.0	134.9	90.3	83.5	
Dade and Broward, Florida	–	56.4	–	64.1	61.3	72.2	66.8	
Florida	59.0	–	74.0	64.1	61.3	72.2	66.8	
Georgia	96.6	92.0	91.8	115.4	110.4	72.2	66.8	
Hawaii	62.4	59.3	109.6	94.9	90.8	63.2	58.4	
Idaho	49.9	47.5	47.4	41.0	39.3	45.1	41.7	
Illinois	87.3	83.1	82.9	102.6	98.1	81.2	75.1	
Indiana	49.9	47.5	47.4	41.0	39.3	45.1	66.8	
Iowa	96.6	74.2	74.0	102.6	98.1	108.3	100.2	
Kansas	59.2	74.2	74.0	102.6	98.1	81.2	75.1	
Kentucky	46.8	44.5	44.4	38.5	36.8	54.2	50.1	
Louisiana	59.2	74.2	74.0	64.1	73.6	72.2	66.8	
Maine	77.9	74.2	74.0	64.1	61.3	45.1	41.7	
Maryland	68.6	65.3	65.1	56.4	73.6	122.8	113.5	
Massachusetts	137.2	118.7	88.8	92.3	88.3	77.6	71.8	
Michigan	84.2	89.0	88.8	102.6	98.1	54.2	50.1	
Minnesota	62.4	59.3	59.2	51.3	61.3	45.1	50.1	
Mississippi	46.8	44.5	44.4	38.5	36.8	36.1	58.4	
Missouri	93.5	89.0	88.8	102.6	98.1	72.2	66.8	
Montana	77.9	74.2	74.0	64.1	61.3	45.1	41.7	
Nebraska	49.9	47.5	47.4	41.0	39.3	45.1	58.4	
Nevada	46.8	44.5	44.4	38.5	36.8	54.2	50.1	
New Hampshire	68.6	80.1	80.0	64.1	61.3	45.1	41.7	
Bergen, New Jersey	121.6	115.7	115.5	100.0	95.7	70.4	85.9	
New Jersey	121.6	115.7	115.5	100.0	95.7	70.4	85.9	
New Mexico	74.8	71.2	71.1	61.5	58.9	54.2	66.8	
New York City	99.8	142.4	142.1	123.1	117.8	130.0	120.2	
New York	99.8	94.9	94.8	82.0	117.8	130.0	120.2	
North Carolina	46.8	44.5	44.4	38.5	36.8	27.1	25.0	
North Dakota	46.8	44.5	44.4	38.5	36.8	27.1	25.0	
Ohio	146.5	154.3	154.0	133.3	127.6	144.4	133.6	
Oklahoma	77.9	74.2	88.8	64.1	61.3	54.2	80.1	
Oregon	90.4	86.0	85.4	64.1	61.3	63.2	58.4	
Pennsylvania	65.5	62.3	62.2	53.8	63.8	72.2	100.2	
Puerto Rico	74.8	71.2	71.1	51.3	49.1	36.1	50.1	
Rhode Island	106.0	100.9	100.7	87.2	83.4	61.4	56.8	
South Carolina	68.6	59.3	59.2	38.5	36.8	54.2	50.1	
South Dakota	46.8	44.5	44.4	38.5	36.8	27.1	25.0	
Tennessee	53.0	50.4	50.4	64.1	61.3	45.1	41.7	
Texas	53.0	50.4	50.4	38.5	36.8	54.2	50.1	
Utah	56.1	53.4	53.3	46.2	44.2	45.1	41.7	
Vermont	77.9	74.2	88.8	64.1	61.3	63.2	58.4	
Virginia	56.1	53.4	53.3	46.2	44.2	32.5	50.1	
Washington	71.7	89.0	88.8	64.1	61.3	90.3	83.5	
West Virginia	46.8	44.5	44.4	38.5	36.8	36.1	33.4	
Wisconsin	59.2	56.4	56.3	48.7	46.6	45.1	46.7	
Wyoming	49.9	47.5	47.4	41.0	39.3	28.9	26.7	
U.S. Average (in dollars)	$66.1	$69.4	$69.6	$80.4	$84.0	$114.1	$123.4	

TABLE III-28.
NATIONAL PRICE AND INDEX FOR HOSPITAL MEDICAL MALPRACTICE COVERAGE, 1960, 1966, 1970, 1972

Year	Premium Cost For Constant Degree of Coverage*	Index for Medical Malpractice Insurance (1966 = 100)	Medical Services Price Index
1960	$ 7,051	86.5	92.8
1966	8,153	100.0	100.0
1970	25,546	313.3	116.4
1972	37,610	461.3	n.a.

*The National Daily Average of occupied hospital beds was 217 in 1960, 207 in 1966, and 193 in 1970. Outpatient visits were 188, 226, and 322, respectively, the 1970 figures were used for 1972.

- Never accept a foreign-trained physician unless he is board-certified, i.e., never insure a foreign-trained general practitioner;
- Refuse to insure all anesthesiologists;
- In Florida, insure no one who practices within ten miles of the coastline, i.e., accept risks only from the interior of Florida;
- Never underwrite a physician who is on the staff of a non-JCAH certified hospital.

A general practice of most regular carriers writing individual policies is that they either accept an applicant at their standard rate or else they decline the risk altogether. In the individual market, few regular carriers will make exceptions and attempt to determine the "right price" for someone not eligible for the standard price. As will be seen, carriers of group plans on occasion do make exceptions.

With all carriers attempting to select out higher-than-normal risks, the question is: If a person happens to be universally classified as a high-risk, how does he obtain malpractice insurance? Historically, two routes have been open to such individuals: group plans or surplus lines carriers, including the London market, i.e., Lloyd's or other British insurers. Surplus lines carriers have always been a small part of the total malpractice market, and with the spread of group plans their share of the market may contract even further. Unfortunately, time and the scope of this project did not permit surplus lines carriers to be sought out and interviewed. Consequently, little is known about features of the policies which they issue (e.g., whether they include deductibles or co-insurance) or the methods and techniques which they use to determine rates for supposedly high-risk practitioners whom they underwrite.[30] Although little is know about details of their operation, it is clear that surplus lines carriers have been an important safety valve in this market.[31] Whether they can or will continue to be a reliable safety valve in the future is not known.

Underwriting group plans

As indicated previously, underwriting of group plans differs significantly from underwriting practices which apply to policies sold directly to individuals. In a group–*endorsed* plan, where a medical society simply endorses a particular carrier, the carrier typically retains his underwriting prerogatives but generally agrees to give medical society members the benefit of the doubt because the group endorsement gives him a much larger book over which to spread the risk.

In group-*sponsored* plans, the hospital association or medical society usually sets up a peer review group to which questionable cases can be or are referred. When questionable cases arise, the insurance carrier presents his view of why the group should drop the risk, and the member presents his view about why he should be continued even though continuation appears likely to cost the group money. In some instances, the carrier reserves final judgement (but usually follows the peer review recommendations) and in other group plans the peer review decision is final and binding upon the insurers.

In return for giving up their usual underwriting prerogatives, carriers expect a high level of participation and a large book of business over which they can spread their risk. They also expect the medical society to go along with or support rate increases when warranted. When participation rates in group plans exceed 95 percent, the group plan approaches the status of privately-sponsored social insurance. In other words, malpractice insurance is virtually compulsory and hence is bought by every practicing physician, yet within the state it is all sold by only one carrier. Most features of the group plan, i.e., everything except rates, are controlled by the group or the carrier and are not subject to outside review or regulation by any public authority. Implications of this situation are discussed further in Sections IV and V.

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[30] The London market is reportedly withdrawing from or limiting reinsurance and primary insurance in the U.S. medical malpractice market. This supposedly is because British insurers are generally not intimate with or current on the rapidly changing status of our unique malpractice law and, because of some large losses, they now have less confidence in their ability to write malpractice risks. No representative of any London carrier was interviewed in connection with this study.

[31] Surplus lines policies are universally brokered by insurance agents.

K. CLAIMS HANDLING AND LOSS PREVENTION

The carriers surveyed utilized several methods of handling claims for medical malpractice. The larger carriers use claims adjustors located in field offices across the country. These adjustors handle claims for all types of insurance written by the carrier. Although certain adjustors might become quite experienced in handling malpractice, the claims handled by adjustors who are inexperienced or unfamiliar with this area create problems both for the carrier and the insured.

Claims handling

Most of the carriers, both large and small, utilized specially trained claims adjustors to handle malpractice claims. Usually there are specific procedures for informing the underwriting department of claims experience. One carrier periodically reviews all its claim files to discover problems which it feels warrant corrective action either by the insured or by the carrier.

Claims are usually reported to the agent or representative of the carrier, who then reports them to the carrier. Policies normally contain a provision that written notice shall be given the company as soon as practicable after the incident occurs. The claim often comes long after the actual incident on which it is based. For example, a doctor may perform an operation and some years later complications arise which lead the patient to accuse the doctor of malpractice. This contributes to the slow development of claims in this type of insurance. Contributing to this problem is the failure of the insured physician to report incidents to the carrier or his agent, especially when there is a likelihood that the incident will result in a claim. Likewise, any tardiness on the part of the agent in reporting incidents or claims further aggravates an already difficult problem.

There was considerable variation in determining exactly what constituted a claim. In any case, most carriers opened a file when they learned of any incident which might lead to a claim or suit against their insured. Carriers reported that often their first knowledge of a claim occured when they were notified by counsel for the plaintiff that suit was being contemplated.

One of the carriers surveyed, American Mutual Liability Insurance Company (which administers a group program for 28 medical societies in Northern and Central California), furnished the profile of claims development for policy year 1960 (Table III-29). The number of doctors insured in policy year 1960 was 3960.

Loss prevention

The main emphasis of the carriers' loss prevention programs for physicians is education. This takes the form of loss prevention seminars, loss control bulletins or newsletters, workshops, and conferences, and appearances at various public and professional meetings. These efforts may be conducted by the carrier, the agent, or, in the case of group plans, the sponsoring association.

For hospitals and other institutions, the emphasis is on safety and training of staff. Carriers usually have engineers on staff or as consultants to work with hospitals in an effort to eliminate hazards and unsafe practices. A great deal of emphasis is placed on orientation and training of hospital staff, as well as establishment of safety committees.

TABLE III-29

DISTRIBUTION OF REPORTED CLAIMS FOR POLICY YEAR 1960 AMERICAN MUTUAL (NORTHERN CALIFORNIA)

Report Periods - Percentage		
18 Mos. - 46%	31-42 Mos. - 9%	55-66 Mos. - 4%
19-30 Mos. - 30%	43-54 Mos. - 10%	67-78 Mos. - 1%

Several of the larger carriers have staff members who work full time in loss prevention efforts such as writing case histories and giving talks to medical societies and professional meetings. Other carriers report that loss prevention is a responsibility of everyone involved including the claims department, underwriters, and the adminstrator of a group plan.

Some carriers surveyed felt that loss prevention efforts were important but were primarily the responsibility of the medical societies. They did not feel it was the responsibility of insurance companies to promote loss prevention. They felt that insurance companies should emphasize the improvement of underwriting and actuarial practices and leave the improvement of medical practice to the medical profession.

Most loss prevention efforts are directed toward group plans. The group offers an efficient means for the carrier to reach large numbers of policy holders. Also, any efforts can be coordinated or presented by the agents or agency administering the plan, thereby preserving the carrier's relationship with the agent. The traditional relationship of carriers with agents sometimes prevents effective communication or loss prevention efforts with individual policy holders. Independent agents maintain that clients belong to them and not to the carrier and resent any efforts by the carrier to deal directly with the insured. This limits what a carrier can do in loss prevention efforts with individual policy holders.

Individual agents sometime present a different problem for hospital group plans. Most carriers have engineers who survey hospital operations and issue a report on safety conditions and inadequate medical procedures. This report is sent to the hospital and the agent. The agent's responsibility is to monitor the implementation of the safety report and to verify to the carrier that the hospital has followed the report's recommendations. This arrangement has produced unsatisfactory results and often the carrier must ask the sponsoring hospital association to intercede on the carrier's behalf to determine if the hospital has made the necessary improvements. The association can exert pressure to insure that conditions are improved and may threaten policy cancellation to get action.

Some carriers feel that the effective use of a professional liability or peer review committee is a promising loss prevention vehicle. These committees usually have the responsibility of reviewing claims and making recommendations to the carrier as to whether a claim should be settled or defended. They also serve as an appeals group when the carrier wishes to deny or restrict coverage for a member. Through their involvement in these two activities, the medical society becomes aware of problem areas and is encouraged to prevent or eliminate them. While there has been some disagreement over the effectiveness of these committees, at least two carriers feel very strongly that they are not only effective but necessary for a successful loss prevention program.

Under the aegis of the group plans, several carriers have successfully broken down some of the barriers between insureds and the carrier. The early reporting of incidents facilitates communication and is perhaps the most effective means of controlling losses. Insureds are encouraged to call a claims representative of the carrier any time they have any indication of a problem that might result in a claim. Not only does this give the carrier early knowledge of potential claims, but it provides the carrier a means of providing the insured with advice and assistance in handling the claim. This may be advice on communications and statements to the patient, the securing of expert consultation, or efforts to settle valid claims before a suit is filed. Carriers believe that increased communications and improved relationships with doctors assist in the fast settlement of valid claims and result in a stronger and more coordinated defense in cases where they feel there is no negligence involved. Reporting of incidents allows the carrier and association to view a larger spectrum of cases where liability may occur. Detection of the causes of malpractice is facilitated by having all incidents reported, and prevention efforts are better formulated with a broader scope of occurrences.

L. REINSURANCE

The United States has hundreds of independent primary casualty insurers. In contrast, the number of United States reinsurers is about two dozen. In addition to domestic reinsurers, the London market is also actively involved in selling reinsurance to United States carriers.

The number of carriers makes the reinsurance market appear relatively "thin", or restricted. It has been alleged that malpractice reinsurance is difficult or even impossible to obtain, and that the nonavailability of reinsurance has contributed significantly to problems in the primary market. These allegations have received sufficient publicity to result in proposed federal legislation which would provide for federal malpractice reinsurance.

In an attempt to gain insight into the validity of the charges and the need for proposed federal legislation, primary carriers were asked about their reinsurance needs and two major reinsurers were also interviewed regarding their knowledge of and participation in the malpractice reinsurance market. No substantive evidence indicated that problems of the individual market could or should be attributed to the reinsurance market.

The limited malpractice reinsurance market

The size of the reinsurance market is limited by the size of the primary market. First, many of the primary writers are so large they have no interest in buying malpractice reinsurance. One company stated, for instance, that they will write limits up to $5 million for a single practitioner, and they will not seek to reinsure any of this risk. This company, although obviously not small, has an annual premium income which is less than half that of several other large primary writers. If one of these larger carriers did, for any reason, want to reinsure above, say $1 million, their size and resources would readily enable them to obtain treaty reinsurance.

A second factor which limits the size of the reinsurance market is that many practitioners apparently buy two policies. The first policy (sold by, say, carrier A) has $100/300,000 limits.[32] The second policy, which is placed with carrier B, is an "umbrella" policy[33] for coverage in excess of $100/300,000. These umbrella policies are sold both in the individual market and in conjunction with group plans. The umbrella policy is a substitute for reinsurance, in the sense that carrier A could sell the whole package and, if it wanted to limit its exposure, reinsure everything above $100/300,000. Since neither brokers nor practitioners were interviewed, the rationale for two policies remains conjectural. However, umbrella policies are available from a number of companies, and by spreading the risk they do further reduce the need for reinsurance.

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[32] This is sometimes referred to as a "basic limits" policy, but it should not be confused with the "basic limits" used by actuaries (5/15).

[33] Umbrella policies typically cover excess or catastrophe losses from a number of sources, but the major portion of the premium is attributable to malpractice coverage.

Some important characteristics of the reinsurance market

The reinsurance market is a professional market in that both buyers and sellers are professional insurance men. Moreover, individual transactions are typically large, which means that even the buyers can afford to spend considerable time and effort becoming professional purchasers. Thus, the reinsurance market contrasts sharply with the primary market for individual malpractice insurance where the typical hospital administrator or individual practitioner may not know where to buy insurance, much less know about the details of coverage contained in the policy; nor will he consider it worthwhile diverting his time and attention to learning about insurance (except, of course, as is absolutely required in order to obtain coverage).

Primary insurers know where the reinsurers are, and vice versa. They read the same trade journals, attend the same conventions and meetings, and generally know one another on at least an acquaintanceship basis. In this sense the reinsurance market is certainly more informed and possibly more competitive than the primary market, even though relatively little malpractice reinsurance is actually bought and sold. Smallness of numbers does not necessarily result in a noncompetitive market since a few professionals trading among themselves can keep one another honest far better than can a small horde of amateurs.

Reinsurance is written on either a treaty or facultative basis. The essential difference between these two is that a treaty applies wholesale to a large number of policies, whereas facultative reinsurance is applied to individual named risks. Most malpractice reinsurance is written on a treaty basis. The reason treaty reinsurance dominates the market is inherent in the way reinsurers operate. They are sometimes referred to as "a bookie's bookie", which is another way of saying that they are professionals dealing with professionals.

A reinsurer is one step removed from the primary market in more than one sense. Namely, when negotiating a treaty the reinsurer spends the great majority of his effort appraising the professional capabilities of the primary carrier. In order to arrive at an opinion of the primary carrier, he may carefully study a few specific underwriting decisions; but in general the reinsurer will base his opinion on a wide variety of other items, such as the insurer's experience and general track record in the insurance business, its marketing plan and concept, etc. The reinsurer spends his time making an intuitive but professional evaluation of the key men in the primary carrier's organization. In general, the reinsurer either has faith in the ability of the primary carrier's underwriting department, or he does not write a reinsurance treaty with the primary carrier. Thus, if a reinsurer's evaluation is favorable and a price can be agreed upon, a treaty will be negotiated. It did not appear that knowledgeable underwriters have any serious problem in negotiating a treaty with a qualified reinsurer, and for knowledgeable underwriters malpractice reinsurance is available in a competitive market on a treaty basis.

This *modus operandi* of reinsurers means that they typically have few employees compared to primary carriers. Their business is to take large risks in exchange for large premiums. What this means, in terms of the malpractice market, is that reinsurers typically do not have any in-house expertise, underwriters or other facility for knowledgeable review of individual applications for facultative reinsurance. For this reason facultative malpractice reinsurance may be difficult to obtain in the United States reinsurance market.

The reinsurers' lack of any real facultative capabilities also means that high-risk hospitals or practitioners can expect to encounter difficulties in the primary market. Nonavailability to high-risks may, to a small degree, represent a meaningful problem in the reinsurance market, but to a far greater degree it reflects serious shortcomings in the primary market, the medical licensing or review process, or both. Discussion and recommendations concerning high-risk problems will be found in Section V.

Smaller carriers obviously need reinsurance more than larger carriers. By the same token, specialized carriers need reinsurance more than multiple or full-line carriers.[34] If a small carrier were to offer malpractice insurance, he would need to offer limits of at least $500,000 (and perhaps $1 million) in order to be a viable writer. At the same time he would need extensive reinsurance. To obtain this reinsurance, he would have to convince a reinsurer that he knew how to write malpractice risks, which means that first he would probably need to hire a team of experienced specialists. Thus, as malpractice becomes a more risky and more specialized area in which to operate, new firms or small firms are less likely to enter this market. Someone desirous of starting a new insurance carrier will start by writing other kinds of lower limit, less specialized insurance (e.g., automobile coverage), and only those carriers which are already established will venture into the malpractice area. It should be noted that the ranks of potential malpractice writers is large because many established carriers do not write malpractice insurance at the present time. If any of these firms made a determined effort to develop inhouse expertise in the malpractice area, they would have little difficulty obtaining malpractice reinsurance. It seems highly doubtful that any established carrier has not entered the malpractice field because of weakness in the reinsurance market.

Problems of Federal reinsurance

If the Federal government were to attempt to provide malpractice reinsurance it would essentially have two options. One, it could mimic existing reinsurers and attempt to screen out underwriters who do not know what they are doing. Or, two, it could substantially relax any underwriting screen and reinsure virtually all comers. Any legislation in this area should be quite clear as to its objectives. At best, either alternative will be fraught with difficulties, and either alternative can easily turn into an exercise in futility.

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[34] A specialized carrier can have his entire financial structure threatened by one adverse legal precedent.

To illustrate, if the Federal government attempts to merely ape the private market, it clearly will have contributed nothing new to the insurance market. In fact, if the objective is selective underwriting and self-sustaining operations, then the closer this objective comes to being fulfilled, the less the government will have contributed and the more it will have taken from what the private market would otherwise have supplied.

If, on the other hand, the Federal government's objective is to set new and lower underwriting standards,[35] the predictable results will be large losses and deficits, hidden health-care subsidies, and less attention and action on the fundamental underlying problem—malpractice. Although the malpractice insurance industry does indeed exhibit certain problems and weaknesses, Federal malpractice reinsurance would not attack the primary problem—incidents of malpractice. Recommendations for overcoming these weaknesses are contained in Sections V and VI.

IV. Discussion

A major concern of this study is whether the insurance industry will continue to make malpractice insurance available to qualified institutions and practitioners, i.e., is the malpractice insurance market collapsing, or is it likely to collapse? To summarize the conclusion of this study, for the foreseeable future insurance will almost certainly be available on a competitive basis from the private insurance industry, but the available sources and channels may undergo significant consolidation and change. Hence broad-scale government intervention or support will not be necessary. State insurance regulators and the federal government can, however, take certain steps which will enhance competition and thereby improve the market. Recommendations for specific action are discussed in Section V, and some suggestions for further research will be found in Section VI.

A. WHY THE CONCERN FOR AVAILABILITY?

Whether concern for availability of malpractice insurance is an appropriate public policy issue is fundmental, and the answer to this question deserves to be established explicitly. An important distinction for public policy issues is whether medical malpractice insurance is a luxury or an economic necessity. To illustrate, appropriate public policy is concerned with whether the public has adequate transportation to enable participation in the labor market, but it is not vitally concerned with whether anyone, including the very rich, have access to chauffeured limousines. To establish that availability of medical malpractice insurance is a matter of appropriate policy concern, one needs to determine where it fits in a spectrum ranging from "absolute necessity" to "super luxury".

Reliable statistics are not available on how many hospitals or practitioners do not have malpractice insurance, but informed observers generally estimate that over 98 percent of all practicing physicians carry at least some malpractice insurance. If a necessity is defined as something which every worker in a particular category needs to have in order to ply his trade, then on a *de facto* basis malpractice insurance would appear to be something of a necessity.

Furthermore, as was indicated in Section III, Sub-section C, the vast majority of physicians carry liability indemnity limits of $100,000/300,000 or higher. For those specialists subject to high exposure (e.g., anesthesiologists, neurosurgeons, and orthopedic surgeons), adequate limits are generally considered to be at least $1 million. Those who wish to be covered for virtually every contingency are generally advised to buy limits of $3-5 million. While chances are small that any practitioner will be successfully sued for more than $100,000, losses in such an event can be quite high, where "high'. means enough to totally bankrupt the ordinary physician. If a surgeon or anesthesiologist were to practice without insurance, all of his personal assets would be "on the line" every time he operated.[36] It is commonly alleged that most or even all physicians would stop practicing if their insurance coverage lapsed. This study has no way to validate scientifically the truth of this statement, but to the extent that it is true, one can also infer that malpractice insurance comes close to being a necessity.[37] As Ficarra, p. 1011 (1968) observed:

> "Any surgeon who would practice for one day without malpractice insurance would encourage dualistic *[sic]* opprobrium. He would be a legal martyr and a medical hebephrenic. The surgeon without malpractice insurance coverage would enter an operating room with trepidation and during an operative procedure would have legal diaphysis at the first threat of a calamitous incident."

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[35] One can build a persuasive argument that the government should attempt to establish underwriting standards which are more knowledgeable, less intuitive and in this sense higher, not lower. But the way to do this is by funding basic studies and research in the underwriting area, not by establishing a reinsurance facility. See Section VI for further specific recommendation.

[36] Anecdotal stories abound in this area. One anesthesiologist reportedly practiced for four days during which his insurance had elapsed, and he is said to now be faced with bankruptcy for an incident which occurred during his four-day interval while he was personally liable.

[37] Of course, a surgeon who contracted for surgery prior to cancellation of his malpractice insurance would be on the horns of a dilemma in that he might be sued for failure to fulfill his contract.

No doubt a similarly cogent statement can be made for institutions and practitioners about the necessity for the continued availability of malpractice insurance.

While the preceding observations and discussion are admittedly impressionistic, they do lend substance to the view that malpractice insurance is not the type of product which a hospital or physician can casually elect to buy or not buy, as the fancy strikes. Rather, it borders on being an absolute necessity. Hence availability is properly a matter of public policy concern. Despite this, it is interesting to note that no state has enacted a "financial responsibility law"–similar to the law applicable to motorists–which would require a hospital or physician to carry any form or amount of malpractice insurance.[38] Since no financial responsibility law requires that malpractice insurance be carried, no legislature has provided that malpractice insurance be made available by anyone on any terms.

B. THE MARKET FOR MALPRACTICE INSURANCE

In recent years it has not been uncommon to hear reports that "malpractice insurance is not available" or that "the malpractice insurance market is collapsing". The frequency of these assertions has doubtlessly played a role in creating the Secretary's Commission on Medical Malpractice.

Early in the study it became apparent that for purposes of analysis the malpractice insurance market is most usefully thought of as being composed of two sub-markets.

- The "group" market in which hospitals or medical associations enter into an agreement to sponsor or endorse a particular insurance carrier.
- The individual or "traditional" decentralized market where a company representative or an independent agent will sell to individual hospitals or physicians.

In the latter market an agent will place the coverage with a carrier whom he represents without any intervening collective action by an association of the insured's.[39] The distinction is useful because within each of these two sub-markets, valid generalizations can frequently be made, but those generalizations typically will not apply beyond the sub-market to which they refer. Similarly, problems encountered in one sub-market often differ from problems in the other. For insurance, it appears that many of the most commonly voiced allegations and problems of availability are associated exclusively with the individual market. Distinguishing characteristics of these two sub-markets are discussed separately in the following sections.

Individual market

The share of the total market sold to individual hospitals or practitioners, independent of any association or group sponsorship, has diminished rather markedly during the last five to eight years.[40] As a result what was already a "thin" market for individuals is apparently becoming thinner. Despite this trend, however, the individual market still exhibits a fair amount of life. Hopefully, this trend is not definitive, and an active individual market will continue to exist as a viable alternative to group-sponsored plans. Nevertheless, the possibility exists that in the next five to ten years group plans may so dominate the market that individual policies will cease to be widely marketed or readily available in particular states or nationwide. As a contingency, one must anticipate the day when, within various states or territories, the group-sponsored plan will have a virtual monopoly on the availability of insurance.[41]

Reasons for the declining trend and general thinness of the individual market are difficult to distill. However, the market appears to exhibit a number of problems, including some built-in-communication barriers as between the three tiers: insureds, agents, and carriers. To ascertain the extent and seriousness of these communication problems would require a survey of physicians and insurance agents, which was beyond the scope of this study.

One symptom of this communication problem is what seems to be a substantial amount of noninformation and misinformation among insurance agents and potential insureds. The number of agents who are moderately well-informed about malpractice insurance appears to be relatively small. As the penetration of group plans increases, the ranks of knowledgeable agents may be thinned even further, presenting an increasingly serious market problem.

Within the individual market, the flow of information between carriers and insureds (or potential insureds) appears to be almost minimal, except in the claims area. For example, most of the interviewed carriers acknowledged that in the event they elect to cancel or not renew a policy, notice is customarily sent *only* to the agent and *not* to the insured. Similarly, in the event an agency agreement between carrier and agent is cancelled or allowed to lapse, all policies placed with the carrier by that agent are automatically not renewed and no notice of nonrenewal or explanation of the reason for nonrenewal is given to the insured by the carrier. In the latter instance the carrier might be perfectly willing to stay with the insured, provided the application came through another of the carrier's agents. However, the insured has no ready way of knowing this. A breakdown in communications between the insured, his agent, and the carrier is responsible for some of the apparent nonavailability.[42] Rationale for this practice of not communicating can be found in the agency agreement, which traditionally gives the agent all "rights" to the insured's business.

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[38] The purpose of a financial responsibility law is to ensure that an insured innocent party will be compensated in the event the injury is determined to result from another person's negligence. An interesting policy question, but one which is beyond the scope of this study, is whether practicing physicians should be required to have some minimal amount of malpractice insurance.

[39] Three carriers in this field are known to be direct writers–that is, they do not use agents–but only one of these carriers writes or solicits individual policies. All other carriers sell through the agency system.

[40] Hard data are unfortunately not available. No prior surveys are known to have been taken in this area, and time did not permit a painstaking reconstruction of all group developments during the past ten years.

[41] Problems arising from this development, as well as recommended solutions, are discussed further in Section V.

A majority of carriers who still write malpractice insurance acknowledged that they never direct any advertisements to the medical profession notifying them about their general willingness to write professional liability insurance. The custom of these casualty underwriters is to place advertisements referring to the company only and not advertise for any particular line of insurance. In other words, they have not singled out malpractice insurance for some isolated form of benign neglect. The market probably suffers little, if at all, from lack of advertised availability in broader, less restricted markets where insurance is readily available from a majority of all local agents. But such a lack of information can be a potential problem in a highly restricted market, where only a small minority of carriers or agents accept applications as part of the normal course of business.

Although a survey of agents, hospital administrators, and practitioners was not part of this study, there is reason to believe that casualty agents engage in relatively little advertising or aggressive marketing effort for individual medical malpractice business among hospitals or practitioners.[43] This is not true in those situations where a carrier has negotiated a group-sponsored or group-endorsed plan, because in these instances the carrier and its agents actively attempt to obtain members for the plan.

On the basis of fragmentary evidence, it also appears that many agents are not well-informed about which carriers are willing to write malpractice policies for individual hospitals or practitioners. It is not known how many agents are so uninformed, nor whether this compounds the problems and frustrations of individuals who inquire about the availability of malpractice insurance. It does seem safe to state that among the universe of all casualty agents and potential insureds, there is not widespread, accurate knowledge about availability of medical malpractice insurance. This is a problem the seriousness of which can only be determined after more is learned about marketing practices at the agent, practitioner, and hospital level.

The possible existence of a serious communication problem indicates that one ought to distinguish between true and apparent nonavailability. True nonavailability exists when carriers determine that they will routinely reject applications and decline to write a particular line of insurance. Apparent nonavailability exists when at least several carriers are willing to accept and review applications on their merits, but the market of potential insureds is totally unaware of which carriers or agents represent viable alternatives. This distinction between true and apparent availability is important for diagnostic purposes. Prescribed remedies clearly differ, depending on the diagnosis. It is generally assumed that more and better information makes a market work better. At a minimum it would seem that these communication problems deserve attention and study by both the industry and the National Association of Insurance Commissioners.[44]

Another potential weakness in the individual market relates to the carriers' adamant dislike of the practice known as "brokering", which represents business brought to a carrier by someone who is not one of its regular agents. Brokering is a normal function in any market, and in general, brokering helps spread information and improves the functioning of the market. This is particularly true in a "thin" market characterized by widespread nonavailability. Carriers indicated, however, that if they knew an application had been "brokered" they would automatically reject it.[45] It ought to be added, however, that the carriers appeared to be making no systematic attempt to investigate or police such brokering as does take place. Hence, it is possible that within the individual market a moderate or even considerable amount of brokering does in fact take place. This is why brokering is more of a potential problem that a real one. Given the apparent widespread noninformation and misinformation which prevails among practitioners, strenuous efforts to eliminate brokering could cause still further disruptions or malfunctions in the individual market.

It appears that the market for individual insurance is characterized by several potential problems with solutions hingeing on improving various types of information. Carriers and state regulators need more and better data in order to determine adequate rates and set proper underwriting criteria. Agents and individuals have no ready source or means for ascertaining which carriers will accept applications. These are clearly real problems. It is not known, however, how widespread and serious these problems are, nor whether these problems are causative or merely coincidental with the decline of the individual market. In order to preserve the individual market as a viable source of competition, succeeding sections contain some recommendations for implementation and some for research.

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[42] In the event of nonrenewal, some agents are said to have failed to notify the insured promptly with the result that a physician was subsequently told that his insurance was going to lapse within one or two days.

[43] One must distinguish casualty agents from life insurance salesmen, who are notoriously aggressive.

[44] Testimony by Mr. Herbert Dennenberg, Insurance Commissioner of Pennsylvania, indicates that the State of Pennsylvania has taken some initial steps in this direction, and the NAIC Industry Advisory Committee on Medical Malpractice will presumably make recommendations in this area. U.S. Department of Health, Education, and Welfare, *Hearings,* before Secretary's Commission on Medical Malpractice, Washington, D.C., December 16, 1971, Statement B.

[45] In part, this attitude is based on the concept that potential insureds will select against the insurance company. But to a degree it also reflects a distrust in their own actuarial and underwriting capability. See Section VI for further discussion of this subject, along with some recommendations for further study.

Group market

The group market differs significantly from the individual market. In particular, communications barriers fall with carriers typically communicating directly with client organizations in negotiations, periodic reviews of rates and loss experience, as well as in continuing loss prevention programs. Problems of brokering and attempts at highly selective underwriting practices are replaced by peer group review, wider selection and assurance that risk can be spread over a large number of insureds. Whereas actuarial and underwriting standards of many carriers selling individual policies appear to be characterized by impreciseness and lack of expertise[46], those carriers now writing or making substantial commitments to group plans are almost uniformly attempting to develop specialists and expertise in all areas: actuarial, underwriting, claims adjustment, loss prevention, etc.

In contrast to the individual market where many carriers have left the market or are passively accepting business, a number of carriers indicated that they are now actively seeking group business. This was generally confirmed by the nine hospital and medical associations which were interviewed in conjunction with the case studies. Only the Pennsylvania Hospital Association gave any indication of nonavailability problems. Those associations which actively shop around should have no difficulty finding competent carriers who will negotiate a group plan on a competitive basis.

Companies with skill and expertise in the malpractice area are attracted by the large premium volume which group plans offer. In addition to the book of malpractice premiums, these carriers and their agents establish a personal customer-seller relationship which can open the door to a substantial book of other business; hospitals also purchase workmen's compensation, general liability, and fire insurance; and practitioners also purchase general liability and fire insurance for their offices, as well as automobile and other personal lines. The realization seems to be spreading that malpractice group plans can open the door to quite a substantial book of profitable business. Hence, competition for group plans is likely to increase, not diminish.

C. SOME SPECIAL AVAILABILITY PROBLEMS

Questions about availability of malpractice insurance need to be discussed in conjunction with the price or cost of such insurance coverage. As the size of jury awards and settlements escalated during the sixties, the predictable reaction was an escalation of insurance premiums. Consequently, it was certainly true that insurance definitely was not available for last year's premium (see Section III, Subsection I). Not only were premiums for any given limits of coverage higher in each succeeding year, but in order for a hospital or physician to obtain the same degree of protection, they also had to raise their limits, thus further escalating their total premium cost. But substantial across-the-board increases in rates does not mean that insurance was not available. For the average risk, it simply meant that the annual premium increased. Nor does the fact that premiums escalated faster than the cost of living mean that the insurance market suddenly started to malfunction. Widespread changes or problems in the insurance market were but a reflection of widespread changes or problems elsewhere (e.g., in the laws, legal doctrines or precedents governing malpractice). Special questions of possible nonavailability do arise, however, in connection with:

- Individual practitioners who, on the basis of past claims experience, are considered to be exceptionally high risks
- Certain specialties which, on the basis of nationwide experience, are considered high risks (e.g., anesthesiologists, neurosurgeons, and orthopedic surgeons), and
- Extremely high future premium levels

High-risk individuals

The first of these "problem" areas, high-risk individuals, does not represent failure of the insurance market. Markets are generally assumed to function within the limits of the law. Until the law is changed, settlements must be based on the existing law of negligence as it applies to the practice of medicine. Within this framework of law, claims and awards, the function of the insurance market is to equitably assess premiums according to risk. That practitioners with a series of nondefensible claims may be denied coverage, or priced out of the market and effectively denied coverage, does not indicate that the insurance market is malfunctioning. Rather, forcing the insurance market to perform this "policing" function long after the fact (after nondefensible acts or accidents have occurred) indicates a lack of any other effective licensing or regulatory function.

It is beyond the scope of this study to consider the necessity or desirability of such regulation, or to formulate any other means of exercising such regulation. Nevertheless, it would certainly be incorrect to equate "regulatory failure" with market failure when the former is closer to the truth. The market is succeeding where all other possible control mechanisms are failing even though the market's "success" is somewhat imperfect.

High-risk individuals who clearly do not qualify for insurance at standard rates can expect to encounter some difficulty in obtaining coverage. The underwriting screen of many primary carriers is somewhat inflexible in that they either accept a risk at their standard rate or else they reject the risk altogether. In part, this may be occasioned by the lack of a good malpractice data base, but even with good data some problem cases of this type will always remain. As observed in Section III, Sub-section L, the reinsurance market is not well-equipped to handle such individuals on a facultative basis either. This group of high-risk practitioners presents one of the real challenges of the present situation. This is the type of problem, however, which can probably be best solved by joint efforts between medical societies and the industry.

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[46] This *emphatically* is not true of a few carriers, especially those smaller carriers who have specialized in the malpractice area. But these carriers tend to be the exception more than the rule.

High-risk specialties

The second of these special problems—where is the malpractice insurance market going in terms of high risk classifications (and, in particular, for the high-risk classifications in high cost areas such as California, Florida, or New York)—is important to anyone interested in the future of the malpractice insurance market. The reason for isolating these groups and areas for special attention is that however unclear the future of the malpractice insurance market may be it is certain that these groups will get "there" first, wherever "there" is.

The rate structure makes clear the specialties and regions for which malpractice insurance problems are most acute. From the interviews conducted in conjunction with this study, a number of anecdotal stories were readily forthcoming. Unfortunately, though, relatively little systematic information seems to exist concerning the problems faced by these specialties. What seems clear is that many of the malpractice problems faced by these practitioners are unique to their specialty. It also seems reasonable to suspect that bringing together all the data, case experience, and anecdotes so as to form a body of knowledge could result in substantial benefit both to underwriters and to the specialists involved. For this reason, it is recommended in Section VI that one of these three problem specialties be studied intensively, with a view towards obtaining indepth documentation and knowledge, along with possible ways to ameliorate the malpractice problem faced by that specialty.[47]

High future premiums

An examination of the rate structure shows that within the high-risk specialty classifications the manual or "standard" premium for a "standard" risk: i.e., a practitioner who may have experienced no claims whatsoever, can easily range up to $7,500 per year. What would happen if future claims experience caused these rates to go to $15,000 per year, or $25,000 or $50,000? Since malpractice insurance is but one of many costs of practicing medicine, these practitioners will either have to pass the cost on to their patients in terms of higher fees, or they will have to accept a lower net income for themselves.[48] Should insurance costs indeed rise to levels which are "astronomical" by today's standards[49], the most likely course of events is that fees will be raised in an attempt to cover the increased costs. Provided that patients requiring operations can pay the increased fees, the increased cost will provide no special economic problem, including "availability", for the insurance market. The potential problem lies in the consumer health care market. The cost of a major operation is already quite high in terms of an average person's income or assets, and if the operating costs should rise substantially higher, their major medical insurance will become even more vital for the average citizen. Malpractice problems thus become another facet in the major problem of delivering health care at a reasonable and affordable cost.

In view of Federal involvement in the financing of health care, escalating medical malpractice insurance rates are a legitimate area for government concern. This concern should be kept in proper perspective, however, and not result in unnecessary and ill-advised interference with the malpractice insurance market.

V. Conclusions

As the discussion of the previous section indicated, for the past decade the medical malpractice insurance market has been in a state of flux, evolving away from the traditional individual market and towards group plans. Laws and legal doctrines have been changing, and in response the insurance market has been characterized by rapidly rising rates coupled with a variety of apparent local nonavailability problems. As a result of this study, it appears that two aspects of the medical malpractice insurance market deserve immediate attention:

- Assurability and safeguards on availability of insurance
- Statistical data gathering and information systems

The findings, conclusions, and recommendations on availability can be summarized as follows. Continued growth of hospital and medical association sponsored insurance plans will probably "thin" the market for individual insurance, and it may virtually disappear over the next ten years. Pure nonavailability does not appear to be a problem because malpractice insurance will almost certainly be available to sponsoring groups on a competitive basis in any foreseeable future. However, heavy reliance on group sponsored malpractice insurance presents two possibly serious problems: first, normal market adjustments in a group setting may be accompanied by adverse, massive impacts; and second, if the individual market disappears, hospital and medical associations will have a monopoly over the issuance of malpractice insurance.

Neither of these possible developments should require Federal action, either now or at some subsequent time. To alleviate the possibility of adverse market impacts, it is recommended that group insurance plans for hospital and medical associations require six months written notice of nonrenewal or cancellation. In addition, state insurance commissioners should have available a standby plan for providing hospitals and medical associations up to six months coverage in event of the carrier's bankruptcy. This provision will give an association time to find a replacement carrier while maintaining malpractice coverage for its members. To protect individual rights from abuses which can arise under a monopolistic situation, it is recommended that state legislatures and state insurance regulators adopt several provisions for safeguarding nondiscriminatory insurance availability. The role of the Federal government should be limited to assisting state regulators and promoting competition among carriers.

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[47] The closed claim survey doubtless contains some useful information along these lines, but time did not permit these data to be reviewed and incorporated into this study.

[48] For some individuals an alternative is to forego their specialties and switch either to general practice or a specialty with lower insurance rates. But although this is an individual alternative, it clearly is not an acceptable social alternative. It would not do for all anesthesiologists, neurosurgeons, and orthopedic surgeons to switch to something else.

[49] Disclaimer: this definitely is *not* a forecast or prediction that insurance costs will rise to such limits. It is merely a theoretical inquiry into the economic ramifications of such a rise in cost, regardless of whether the probability of occurrence is less than one-tenth of one percent.

A widespread need exists for substantial improvements in the collection and availability of statistical data. To achieve the desired improvement, three tasks need to be implemented. First, a uniform statistical reporting plan should be established. Second, all insurance carriers should be required to report their data to a single collection agent. Finally, the collection agent should compile the data, insure its accuracy, and make it available to state insurance regulators, carriers, and all other interested users. Such an effort will, among other things, help preserve competition in the malpractice market. To this extent the Federal government has a contribution to make. However, the Federal government's role should be limited to promoting and providing more and better information on the entire malpractice problem. In addition to the recommendations in this section, several suggestions for further research which might improve the stability and viability of the malpractice insurance market are contained in Section VI.

A. ASSURABILITY AND SAFEGUARDS ON AVAILABILITY OF INSURANCE

Medical malpractice insurance was initially sold in a totally decentralized market by individual agents or company representatives of individual institutions or practitioners. In the early 1900's, the concept of association or group-sponsored insurance arrangements evolved, and since that time both individual and group markets have coexisted. In addition, "true" group malpractice insurance existed until the early 1950's.[50] As indicated in the previous discussion of group plans (Section III, Sub-section E), the recent period of escalating claims and settlements has led some insurers to conclude that group-sponsored plans offer a superior way of marketing and serving the particular needs of the medical malpractice insurance market. The discussion in Section IV also indicated some potential weaknesses or problems in the individual market.

If group plans do in fact have substantial inherent strengths or advantages over the more decentralized system of marketing individual policies, then competitive marketing will ultimately lead group plans to dominate the scene. It is possible that both the hospital and practitioner markets may evolve to the point where group-sponsored insurance plans totally dominate within geographical areas such as states or groups of counties or even throughout the country. That is, within the next five to ten years the market could reach the point where hospitals and practitioners each have 52 to 55 group plans, i.e., 50 states, plus District of Columbia, Puerto Rico, Northern *and* Southern California, etc. If hospital and medical associations were to sponsor an insurance carrier jointly, the number of group plans for which carriers could effectively compete might be substantially less than 100.

Contemplation of this possibility should not be construed as a prediction or forecast that this evolution will occur. However, the probability of this evolution occurring within the next ten years is sufficient to warrant prognostication about potential problems before they arise. In fact, the dominance which group plans have already achieved in some states is sufficient to warrant such inquiry. Before group plans come to totally dominate this market, two major questions ought to be considered.

- *Assurability:*
  Will carriers compete actively for group business and thereby assure that insurance will be available to the membership?
- *Safeguards:*
  What problems might arise if hospital or medical associations come to have a monopoly over issuance of malpractice insurance?

Assurability: long and short term availability to groups

On the basis of information obtained from interviews with both insurance carriers and group associations, malpractice insurance is now readily available to groups on a competitive basis. In those instances where groups had "shopped" or invited proposals, they received several competitive proposals from which to select and negotiate. These groups included those geographical areas generally considered most difficult to insure (e.g., Southern California and Florida). Significantly, the proposals were submitted by financially strong carriers with sufficient assets and reserves to underwrite high malpractice risks. Moreover, several carriers were found to be actively formulating and initiating proposals aimed either at state associations which do not now have a group plan or those state associations thought to be receptive to a new proposal. Thus, when an association has adequate time to formulate its needs, marshall its claims experience for actuarial review, and solicit proposals, it finds a competitive market where a mutually agreeable plan can be negotiated with a qualified carrier.

Given adequate time for the market to function properly, there appears to be no foreseeable shortage of competitive supply from responsive carriers. The stress here is on

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[50] A "true" group exists when a single master policy is issued for all members of the group.

"adequate time to function properly." Group plans do not come into existence overnight nor do they change hands frequently during a short-term interval such as two or three years. Neither insurance carriers nor associations enter into group plan commitments lightly or hurriedly. Consequently the group market needs ample time for it to function effectively.

Once a group plan achieves a high level of participation, the problem of market adjustment takes on new dimensions. As indicated, the group market is not likely to be extremely active in terms of numerous and frequent "switches" from one carrier to another. At the same time, it is both impractical and undesirable to think of all group plans as being a "permanent" relationship. The normal expectation is that some groups will, from time to time, shop around and that carriers will occasionally withdraw from the risk. At the same time, insurance coverage cannot be allowed to lapse on an areawide basis for an interval as short as one day. Consequences of such a lapse in insurance coverage would be socially unacceptable, particularly in a state where all policies have a common termination date. To illustrate, if anesthesiologists and surgeons refused to work without the protection of insurance, every operating room in a state could be shut down by a lapse in insurance coverage. The challenge of the group market is to permit normal market functions to occur while minimizing any short-term disruptions which might be caused by a particular carrier's nonrenewal or cancellation of a group plan. To achieve this, two recommendations are made.

- Every group agreement should require, in writing, that the carrier give the association six months notice of any intent not to renew or to cancel, and such notice of intent should not be effective until received by the association.
- In the event coverage lapses due to bankruptcy, state insurance commissioners should have available a contingency plan for immediately providing continuous coverage for a short run period of up to six momths.

The first recommendation requires action only by the insurance industry and hospital or medical associations. No Federal or state legislative action is necessary. The emphasis is on written notice, because the consequences of abrupt nonrenewal are simply far too serious to be left to oral understandings.

The second recommendation likewise requires no Federal action, but it does require that state insurance regulators have a standby plan. Emphasis is deliberately placed on a short-term six month stop-gap. Within such a time period any group should be able to negotiate an agreement with some insurance carrier. Apparent market failure for any longer period should demand and receive legislative attention at the time and place where it occurs.

The findings and conclusions of this report are that no other action by either Federal or state government to assure availability is either necessary or desirable at this time. In fact, long-term failure can easily be occasioned by over-regulatory zeal, which to date has been the source of most cases of reported market failure.[51] It is imperative that state governments not provide regulators with a shield which can hide their own mistakes and errors.

Safeguards: protection of individual rights

As indicated above, it is conceivable that the market will evolve to the point where malpractice insurance is available only through hospital or medical associations and the carriers whom the associations sponsor or endorse. Group insurance will be available at a competitive price so long as a number of carriers compete actively for group business, and continuation of competition at this "aggregated" level is almost certain. However, malpractice insurance has become virtually *de facto* compulsory in order for each individual physician to practice medicine. The spectrum of only group availability raises issues which are extremely important and warrant the Commission's immediate consideration.

Evolution of the market towards total reliance on group plans vests sponsoring organizations with an undesirable high degree of monopoly power over hospitals or physicians. If malpractice insurance is *de facto* compulsory and the medical or hospital association has effective veto power over issuance of all such insurance within the state, then the insurance mechanism will in time restore to the medical society the same monopoly power as it had when society membership was an absolute prerequisite for hospital staff privileges, and it will bestow upon hospital associations a power which they have neither sought nor had.

In the market for individual insurance, any single company can be notoriously capricious about whom it declines to underwrite. So long as the individual market place is truly competitive, this capriciousness is of no great concern because a qualified buyer who is turned down by one insurer can always find another willing seller without great difficulty. In a restricted market, however, a capricious refusal to sell can become a significant barrier to limit or restrict the practice of medicine by otherwise qualified individuals. For this reason the power to capriciously restrict insurance, even if this power is latent and unexercised, is a matter of vital public concern. Remedies to this potential problem lie in two directions.

- Steps designed to preserve a competitive individual market as a viable alternative.
- Safeguards to minimize abuses and preserve individual rights as much as possible, should a monopoly control arise despite efforts to the contrary.

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[51] This is acknowledged in the interim report by the NAIC (1972) where it correctly states that all statewide threats of withdrawals from the market have been occasioned by inadequate rates, which in turn were caused by overregulatory zeal.

Preservation of the individual market

The malpractice insurance market appears to be characterized by a great deal of misinformation and noninformation at every level. Since an uninformed carrier can lose considerable money in this market, especially if he has only a small book of business and lacks whatever protection comes from spreading the risk among a large number of insureds, it is possible that all potential suppliers of individual insurance may in fact become unwilling sellers. Should this event come to pass, it does not seem likely that direct government intervention with the market process (e.g., offering Federal reinsurance) will offer any real hope of preserving competition. Unless the government blindly assumes most of the bad risks, such direct intervention by either Federal or state government would be equivalent to treating only the symptoms of market failure at great cost to the taxpayer, rather than the root causes of the malpractice problem.

The best hope for preserving competition in the individual market lies in the direction of effecting major improvement in the quality and quantity of available information and data. An improved data collection and dissemination effort is recommended in Sub-section B. Improved knowledge about the entire malpractice area can only result from a series of indepth studies into all facets of the malpractice problem.

Without detracting from the quality of the studies being conducted under the aegis of this Commission, it is fair to say that these data-gathering and analytic efforts have just begun to scratch the surface, and a great deal of additional useful information can be obtained from further study. In this connection the recommendations for further research contained in Section VI, become extremely important. It is clear from testimony before the Commission and from those studies now being conducted that virtually no systematic research has previously been conducted in this area. If blame for this neglect is to be assigned, it probably lies with the Federal government, since no state insurance commissioner, no insurance carrier, and no organization sponsored by insurance carriers has responsibility or resources for such research. Sponsorship of studies and development of knowledge about national problems is primarily the responsibility of the Federal government. This is one area where the Federal government has an undisputed comparative advantage.

One cannot be absolutely certain, of course, that increased knowledge and information will make the individual market more viable. A danger always exists that the opposite will in fact occur. That is, as more knowledge becomes available about this market, the indication to all carriers could be, "Avoid it like the plague." Still, the best chance of preserving the individual market appears to lie in the direction of increased information and knowledge.[52] A market characterized by widespread ignorance, myths, and misinformation is generally a somewhat unstable market at best, with major unsettling fluctuations around some equilibrium.

Safeguards in a restricted market

In a restricted market, the basic concern is with fair and nondiscriminatory availability of insurance to a "qualified" practitioner or hospital. On the one hand, a legitimate need exists to review a physician's or hospital's capabilities and restrict the practice of those not qualified. Not all physicians continue to be current in their specialties, and physicians can age and slowly grow infirm or develop debilitating diseases (e.g., Parkinson's disease or arthritis). Also, hospitals, like all institutions, suffer from periods of inferior management. Hence, the need for continuing review of capabilities. On the other hand, certain practitioners and hospitals may from time to time wish to pioneer methods or techniques of health care delivery (e.g., HMO's) which violate traditions of the medical profession and thereby encounter hostility and dislike from the mainstream of the profession. Medical organizations have not established beyond reasonable doubt that they are immune to or removed from internal politics. Also, individual discrimination can arise for any number of personal reasons. Provided that the professional qualifications of any such practitioners or hospitals are not at issue, the right of individuals and institutions to pioneer (or just practice) medicine must be protected.

A desirable development in connection with availability of insurance through group plans would be to make it generally available to every licensed physician or hospital in the state, regardless of whether he or it is a dues-paying member or the state or county association. Since no association has a "true" group plan with a single master policy, this would mean that a nonmember practitioner or hospital would have no voice in electing officers of the association, and no voice in negotiating with, selecting, or approving the carrier or the plan. But nonmembership would not (and should not) mean inaccessibility to group-sponsored insurance.

As the market becomes increasingly restricted and monopolistic, nonissuance of insurance means inability to practice or operate. Under these circumstances it thus becomes increasingly important that group plans develop a more flexible stance towards issuance of insurance. It is therefore recommended that the Commission:

- Urge every state to enact whatever legislation is necessary to make the provisions of group insurance plans subject to review by the state insurance commissioner.

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[52] It seems to be widely felt that group insurance plans have, at long last, introduced some form of long-needed internal policing over practices by the medical profession. This may indeed be the case. It is beyond the scope of this study to determine whether the medical profession does or does not need more policing and supervision. However, such policing could be achieved without tying it to the insurance mechanism. In general, neither insurance carriers nor the insurance industry are well suited to the role of "policemen."Licensing, review, and regulation are usually better off if left to other channels. This philosophy is basic to the belief that all reasonable efforts should be made to retain competition in the individual market.

- Provide that an institution or physician may be denied coverage only for reasons which can be reasonably ascribed to undue risk (e.g., for reasons such as previous loss experience or development of debilitating handicaps).
- In the event an institution or practitioner is denied coverage by the group, provide that upon request those denied coverage shall be entitled to a public hearing and review before the insurance commissioner. Also, they shall have the right to be represented by counsel and review all charges or reasons preferred for denial of coverage.

How to insure certain high-risk practitioners and hospitals, i.e., those with a number of nondefensible claims, also presents an important challenge to the medical professions, state insurance regulators, and the insurance industry. It has already been recognized that highly selective underwriting approaches characteristic of the individual market are neither appropriate nor acceptable to widespread group plans. Consideration and thought need to be given to all feasible solutions to the high-risk problem. Possibilities which a regulatory agency of a medical profession must entertain include placing limitations on coverage in the insurance contract (e.g., an orthopedic surgeon's policy may explicitly exclude coverage for any back operation—"laminectomies"—thus perhaps limiting that man's practice chiefly to broken arms and legs). Other insurance possibilities include surcharges, "high" deductibles (e.g., $10,000–$25,000) and co-insurance.

Blindly insuring or reinsuring such persons clearly provides no real solution to the underlying problem; hence a Federal reinsurance facility is not recommended as even a partial solution. Although this study did not weigh the various alternatives and has no particular solution to offer, high-risk practitioners constitute and will continue to constitute a small but very important problem for malpractice insurance The recommendation to the Commission is that the problem of insuring high-risk practitioners should be studied until acceptable solutions are found.

B. STATISTICAL DATA GATHERING AND INFORMATION SYSTEMS

A few carriers have good but limited internal data available to them. However, comprehensive data on malpractice insurance in even the most elementary form is sadly lacking because most malpractice writers do not file their data with the Insurance Services Organization (ISO), which is the only designated statistical filing agency for malpractice data.[53]

Nonfiling of data can occur for any of several reasons. For instance, not all malpractice carriers belong or subscribe to ISO or some carriers (especially those with group plans) may use a different rate classification scheme. As previously noted, group plans exhibit a marked tendency to subdivide ISO classifications, either geographically or by specialty, and file separate rates.[54] Once a carrier has elected to file separately with the state insurance commissioner, filing with ISO is an extra expense from which the carrier can expect to derive little benefit.

Gravitation of the market to widespread group insurance plans will tend to aggravate rather than ameliorate this situation. As a single carrier gains control of more than 50 percent of the market in an individual state, it has increasingly less incentive to file its data with ISO. Even those instances where the carrier uses the ISO rate classification scheme, it will have little reason to file with ISO if by virtue of having the group plan within a state, it has the bulk of the state's experience. The carrier will have relatively little to gain, information-wise, from filing. Were the carrier to file with ISO, it would be assessed a charge based on reported premium even though other ISO members would gain far more than the reporting carrier in terms of information exchange.

In addition to lacking a widespread base of malpractice data, the quality of the entire ISO data base has been seriously challenged by the New Jersey Insurance Commissioner,[55] who is reported to have audited some insurance carriers' closed claims files and compared "actual" data items with the same items as shown in ISO's files. Discrepancies between the two were reportedly so gross that the only possible recommendation is that all other state insurance regulators should undertake similar spot audits. Officials of ISO acknowledged that they do not audit any of their data base used to set rates. In a study such as this, it is and was possible to obtain data from individual carriers who do not report to ISO. However, lack of uniformity in the collection and reporting of data is another major obstacle to obtaining larger data base.

Lack of a comprehensive data base does not, by itself, establish the rationale for an improved statistical collection effort. This is best done by stating explicitly the objectives of improved malpractice data collection. At least three major objectives ought to underlie an improved statistical collection effort.

The first major objective is to foster knowledgeable and informed competition. Over the long run the best means of assuring continued availability and "regulating" prices is by healthy competition between a variety of independent carriers. The role of the government should be to foster competition, not impede it. However, when an insurance market is characterized by growing frequency and high severity of occurrences, coupled with highly intuitive decision-making based chiefly on hunches and guesstimates, the likely result is a highly volatile market characterized by waves of carriers entering and leaving. Volatile markets are not *per se* bad. But in market having communication channels between carriers and potential insureds clogged by traditional barriers, and where the nature of work performed by insureds demands virtually universal and continuous coverage, a more stable equilibrium is probably desirable.

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[53] For policy year ended December 31, 1969, physicians and surgeons malpractice premiums reported to ISO (all states) were less than $33 million, which is less than 25 percent of the estimated market.

[54] See Section III, Sub-section H for a detailed discussion of acturial practices and limitations.

[55] See *Journal of Commerce*, September 23, 1972, p. 23.

A second major objective is to provide a wider and better base of useful information to state insurance regulators or consulting actuaries who may be hired as auditors by insureds. Stated otherwise, existing regulators should be provided with assistance in the collection of statistical data. Another tier of regulation is most explicitly not needed, as this would only act to interfere with the first objective. Findings of this study agree with the recent NAIC Industry Advisory Committee on Medical Malpractice which states, "Central data collection (not rate making) is a prerequisite for decision-making in the malpractice area." (NAIC, 1972, page 42).

A third objective is to develop an actuarial data base which will lead to more equitable rate structures and focus attentions on all problem areas where special research on causes of claims or loss prevention may be necessary.

In passing, one "nonobjective" should also be noted. Namely, a continuing data gathering system should not attempt to serve the needs of basic research. Such research tends to address itself to one-time *ad hoc* propositions. It is both an exercise in futility and an abuse of large-scale computer capability to attempt to amass and store large quantities of data for such needs. Attempts to design data systems for possible research rapidly assume monstrous proportions. Anthony (1963) clearly states the distinction between continuing, repetitive management needs such as rate setting and rate review and one-time decision needs which require *ad hoc* research.

To fulfill the objectives and needs in the statistical information area, three prerequisites should be met:

- Establishment of a uniform statistical reporting plan.
- Universal reporting according to the plan.
- Universal availability of the basic data.

Problems and steps in the implementation and achievement of these three prerequisites are discussed in the following sections.

Statistical reporting plan

The first step in acquiring a uniform, comprehensive data base is to establish a uniform statistical reporting plan which will satisfy the basic requirements of both state insurance regulators, carriers, and other interested parties. Such a plan must generate a data file which will enable actuaries and others to study possible new classifications as well as confirm the soundness of all existing classifications. This requirement is probably not met by the existing ISO reporting plan which is based on a low common denominator level of detail.

The selected statistical agency, or the supervising agency, should have the authority to require reporting in accordance with a prescribed statistical plan, and to make necessary examinations of insurer records to maintain the quality of its statistical data.

The plan should be designed to generate adequate statistical data to refine the rating classification system so that it more accurately reflects the loss exposures involved in the various medical specialties. Variations in loss exposures among individual doctors and among rating territories also may be more accurately reflected.

Rates are now quoted on the basis of one year of exposure for one doctor. However, it is apparent that a teaching physician who maintains a part-time private practice does not have the same exposure as a comparable physician who maintains a full-time practice. This difference in exposure might be reflected by rating on the basis of the number of patient visits, on annual income from medical practice, or on some similar variable basis. Income from practice would reflect the economic status of the doctor's patients, in addition to the number of patient visits. However, it is likely that professional liability claims also are a function, at least to some degree, of the economic and educational status of the patient.

Other factors which might be considered in a more refined rating structure include:

- The past claims experience of the physician and his immediate associates
- The number of years engaged in the practice of medicine
- Extent of medical training
- Certification, or lack thereof, by the appropriate medical organization
- Use of informed consent
- Hospital affiliation
- Existence in the community of an effective peer review committee, and others.

The basic limits amounts for medical professional liability insurance should be reviewed more frequently than at present. Since basic limits rates are calculated on the basis of state data, and excess limits factors are calculated on the basis of national data, lower basic limits effectively shift more of the burden of professional liability insurance from the physicians in the high exposure states to those in the low exposure states.

It is recommended that the Federal Insurance Administrator, in conjunction with representatives of the NAIC and interested insurance carriers be charged with developing a uniform statistical reporting plan, and that the FIA be charged with drafting legislation for the Congress designed to achieve uniform reporting in the medical malpractice area.[56]

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[56] Alternatives where responsibility for such an effort could be lodged are NAIC, ISO, or National Association of Independent Insurers. Neither ISO nor NAII has ties to all interested parties. In addition, NAII has virtually no experience in this area, whereas ISO may have a strong vested interest in its existing plan, which is grossly inadequate in terms of the minimum requirements visualized here.

Universal reporting

The best reporting plan will be only as good as the data which are actually reported in conformity with the plan. Hence, universal reporting of experience by carriers is not only desirable but absolutely necessary if the reporting plan is to be effective.

State insurance commissioners currently have authority to require statistical filing within their own state, but there exists no precedent with NAIC or the industry for universal filing according to an approved uniform plan. It appears that some form of Federal legislation will be necessary in order to assure universal filing. It is recommended that the FIA be charged with drafting and submitting such legislation to Congress.

If Federal legislation is to require such filing, then it is logical for that legislation to specify that the data be filed with the FIA. Filing with the FIA will also help satisfy the availability requirement, which is discussed in the next sub-section The FIA can and probably should subcontract out all aspects of the physical handling of the data, either to one of the existing filing organizations; i.e., ISO or NAII, or on the basis of competitive bids, to any private organization with adequate computer capability to handle the job. Precedent for this data handling procedure by the FIA already exists.

One final related matter concerns quality of the reported data. That is, to what extent are the numbers which are finally recorded in the data files the same as the numbers recorded in the claim files? The quality of ISO data is not without question. As noted previously, a recent press report indicates that an audit by the New Jersey Insurance Commissioner uncovered some gross discrepancies. What is needed are recurring audits (on a sample basis) of the data as well as internal consistency and validity checks by the statistical agency. Although state insurance commissioners have authority to audit loss data used to support rate filings, it appears that loss data are in fact audited only rarely. The FIA should be charged with responsibility for necessary audits. Until such legislation is enacted, state insurance commissioners should be urged to audit loss data used to support malpractice rate increases. This would doubtless help to allay legitimate fears and nagging doubts of the health care professions.

Universal availability

Two major objectives of developing a broad statistical base are to foster knowledgeable and informed competition by all interested insurance carriers, and to provide a body of consistent, accurate information which will be useful to state insurance commissioners, state medical associations or their consulting actuaries and others. Many such users will wish to manipulate the data in any number of ways, and the way to supply them with this capability is to make the basic data tapes available. Unless the basic data are made available on a nondiscriminatory basis, similar to the manner in which the U.S. Bureau of the Census sells its data, the major thrust of this recommendation will have been lost. It is absolutely necessary that any legislation in this area provide for such availability.

In order to assist state insurance regulators in carrying out their responsibilities, the FIA should supply each of them with some minimum amount of information each year without charge. Whatever is supplied should be tailored to the needs and requests of each state. The central statistical agency should serve the user, and not vice versa. For example, those state insurance departments which employ actuaries and have ready access to computers may want the basic data tapes for their state plus a summary of national loss data. Other states, with fewer internal capabilities, may prefer to have summary printouts which they would specify. Still other states might prefer to receive nothing directly from the central data sources, but instead have ISO or the individual companies obtain the data and process it prior to submittal.

Summary

Actuarial data in the medical malpractice area are generally not good. No data collection agency can overcome the problem of the long time lag in reporting and settling of claims, but a good central data collection effort can go a long way toward alleviating many other problems in this area. The Federal government should assist state regulators and the insurance industry in this area by helping to establish a central data collection effort.

VI. Recommendations for Further Research

Previous sections have indicated several areas where the available data or information were not sufficient for fully identifying problems or formulating policy recommendations. This section contains six specific recommendations for further research in areas related to the malpractice insurance industry.

A. A survey of insurance agents and insureds to determine how much each group knows about the procurement or availability of malpractice insurance.

B. An intensive in-depth study and investigation of the problems of one high-risk specialty.

C. A survey of state licensing requirements to ascertain the extent to which physicians ever have their licenses revoked or have restrictions placed on their right to practice medicine.

D. An in-depth study of hospital and practitioner group plans to ascertain and document the plans' strengths and weaknesses.

E. An investigation into loss prevention and claims handling activities of insurance companies, with a view toward sharing knowledge and experiences which can improve the quality of health care or otherwise reduce the frequency or severity of losses.

F. An investigation into the implications of making malpractice insurance truly compulsory rather than *de facto* compulsory.

Discussion and further delineation of these proposed projects follows.

A. SURVEY OF INSURANCE AGENTS AND INSUREDS

As discussed in Section IV, it is important to distinguish between the situation where carriers universally decline to write individual malpractice insurance policies; i.e., a "true" nonavailability, and the situation in which would-be buyers and the average or typical insurance agents are uninformed; i.e., a number of carriers will routinely accept applications and issue policies to individual insureds; i.e., "apparent" nonavailability. If the first situation existed some form of Federal insurance or reinsurance could well be required. The second situation would require little more than the provision of better information.

Diagnosis of this potential problem area was severely hampered as no systematic or reliable information was available from hospitals, individual practitioners or insurance agents. Several major carriers indicated that they have written malpractice insurance continuously throughout the 1960's. Nevertheless, it would be most interesting to document viewpoints from other participants in this market. Therefore, in order to pinpoint problems of availability in the individual market, it is recommended that the entire market, i.e., hospitals, individual practitioners, and insurance agents, be surveyed, rather than just carriers. If it is good public policy to strengthen and preserve the individual market, then it is important that weaknesses or potential problems in this market be surfaced and solutions developed. Otherwise, this market may suffer a severe competitive disadvantage from the rapidly developing group plans.

In addition to documenting what hospitals and practitioners know about the availability of insurance, such a survey could also develop a variety of other useful information pertaining to the general malpractice problem. It would be interesting, for instance, to see how hospitals and practitioners view the loss prevention and claims adjustment activities of carriers. Documenting practitioners' experience and obtaining their views on malpractice claims, peer review panels, and the practice of medicine by others, would also seem worthwhile.[57]

B. INVESTIGATION OF HIGH RISK SPECIALTIES

As Section IV indicated, one way to inquire about the future of the malpractice market is to focus on the high risk specialties. Testimony and evidence turned up during the Commission's hearings and this study indicates how little is really known about even the most basic facts. Contradictory anecdotes abound and are of little help in clarifying the issue.

For instance, it seems unclear whether malpractice claims arise chiefly from "hard, difficult" operations or from "routine" operations like tonsillectomies. By the same token, it is not known whether malpractice claims arise chiefly from university or teaching hospitals and "top-flight" practitioners (because they take on more of the "hard" cases) or from "second-echelon" hospitals and their staff. Some informed observers feel that the hospital where a physician practices is quite important in determining the likelihood that he will be sued for malpractice, but no documented information on this score could be found.

Lack of more systematic data or knowledge in this area hampers every area where improvements might be effected—loss prevention, actuarial practices, and underwriting. What is needed is a pioneering indepth investigation into a large number of case histories and the problems of any one of the high-risk specialties. To be effective, such a study would almost certainly require the sponsorship or elose cooperation of the specialty college involved.

The major purpose of such a study would be to collect as many case records as possible from the last 10 to 12 years and then obtain all the useful feedback which is possible from these data. This would be a major statistical effort to determine how many events were in some sense "preventable" and which events had greatest frequency of occurrence. Such a study would contrast sharply with the decentralized, piece-meal, anecdotal approach which is now used for feedback, education, and prevention. From the viewpoint of social cost, the greatest payoff from such a study would come from information which could be used to reduce either the severity or frequency of malpractice.

A second purpose would be to improve significantly the existing actuarial and underwriting standards and practices. One direction of actuarial improvement could be further refinement of the clasification schemes now in use. A different line of possible improvement, and one which has far more social significance, involves development of rating techniques based upon controllable variables. This means, in other words, that rates or rate differentials would be based on factors over which the practitioner has personal and individual control. Under such an approach insurance rates would act as "signal" and would give "rewards", i.e., discounts or rate reductions, to each practitioner who engaged in socially desirable behavior.[58] This concept does appear in auto rate making, where drivers now pay extra to insure a "muscle" car, or are given a discount for driving a car with a safe bumper, or are insured by certain low-cost companies only if they do not drink.

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[57] It can be revealing to inquire not only about how one views himself, but also how he views others. This point was perhaps brought home most forcefully by two General Motors surveys, where the first survey asked car owners how they ranked their own preferences concerning desirable features in a car, and the second survey asked what they perceived their neighbors' preferences to be. The results were dramatically different with the second approach yielding more accurate information about car buyers' underlying preferences.

[58] This concept is somewhat foreign to insurance rate-making as practiced today. But the concept is far from new. It is generally attributed to Adam Smith *(Wealth of Nations*, 1776), who perceived that market prices could, like an "invisible hand," lead people to do that which was socially desirable, even though each individual reckoned only in terms of his own self-interest. Despite all their complexity, insurance rate structures frequently give the appearance of going to great length to frustrate Adam Smith's principle, i.e., they base rates on everything *except* controllable variables.

Underwriting, actuarial, and loss prevention departments contrast rather sharply in the way they view people. Underwriters typically rely heavily on intuition about a person, including his appearance, behavior, and other personal factors. Actuaries, on the other hand, go out of their way to avoid investigating or validating any such "personal" variables, and they give the appearance of being almost totally unconcerned about personal characteristics. This is typically done in the name of "objectivity." The net result, however, is that all differentiating factors in the rate structure are beyond the control of the insured.[59] The chief premise of loss prevention, by contrast, is an underlying faith that physicians' behavior can be favorably influenced even though the rate structure denies that any built-in rewards are to be had from such behavior. Paradoxically, several insurance carriers have testified that physicians are extremely conscious of and responsive to price differentials, but at no time did they perceive that such consciousness could be directed towards mutually and socially desirable ends via the rate structure.

C. LICENSING OF PHYSICIANS

With the spread of group plans, the insurance mechanism is evolving as a means of establishing peer group review and exercising a certain form of control over physicians.[60] It would be foolhardy for insurance companies to become directly involved in the control mechanism, and they have wisely left this completely up to the medical societies involved. Insurance and policing are separable and distinguishable, and private profit-seeking insurance companies are not well-suited to play the role of social regulator or licensing agent.

A widespread assumption is that when a person is once licensed by the state to practice medicine, that license is never again questioned, voided, or restricted in any way as a result of the way he subsequently practices medicine.[61] The subject of continuous review and possible requalification of physicians is generally controversial, and assumptions like the one just quoted are typically bandied about with no more than hearsay evidence to support them. If peer review is a desirable end in itself, then there ought to be a way of achieving that review without vesting the medical society with a monopoly over the issuance of insurance.

The purpose of this proposed study would be to ascertain who in each state exercises authority over the licensing of physicians[62], how that licensing authority has been exercised over the last ten years, and how the situation might be improved without resort to the insurance mechanism.

D. HOSPITAL AND GROUP PLANS

The case studies of group-sponsored insurance plans, carried out as part of this study, were executed on an extremely tight time schedule. This precluded an in-depth investigation into all aspects of group plans. In addition, only a minority of all plans in existence were studied. By their very nature group plans involve a large number of people, and to investigate adequately the many facets of a group plan, it may be necessary or desirable to interview as many as 10 to 15 people. This is particularly true in those situations where the plan has been switched from one agent and carrier to others (for example, see the studies of Florida or Southern California Medical Associations in Appendix A). In those instances where there are lingering recriminations, hard feeling or just plain second-guessing, one encounters conflicting stories which require additional double-checking and investigation. Some of the people whom one can anticipate interviewing are:

- Current president and officers of the medical society
- Past president and officers of the medical society
- Permanent administrative staff of the medical society
- Current insurance agent or broker
- Previous insurance agent or broker
- Current and previous insurance carrier's local (field) representative(s)
- Current and previous insurance carrier's home office representatives from the marketing, underwriting, claims, and actuarial departments

Purposes of such documentation would be twofold. First would be to ascertain any problems or difficulties which groups may encounter in establishing a plan and procuring a carrier (no newly established plans were surveyed in this study) or in switching an established plan to another carrier. Second would be to investigate any problems of availability through the group.

E. INVESTIGATION OF LOSS PREVENTION AND CLAIMS HANDLING ACTIVITIES

Practices vary widely between different companies. Within the individual market, for instance, at least one carrier conducts an extensive and continuing loss prevention campaign among its insureds, but most carriers engage in no significant loss prevention activities outside groups. Paradoxically, these same carriers, while they feel for one reason or another that they are proscribed from any loss prevention activities among individual insureds, are active supporters of loss prevention in connection with group plans. Relevant questions to be answered are:

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[59] Actuaries have raised a number of spurious objections to this suggested approach. For example, it is argued that rates would become too complex, but this objection ignores the fact that further complexity could not reduce understanding because over 90 percent of all buyers probably have no understanding whatsoever of existing rate structure. Or, it has been argued that "the number of cells would become too large." But this argument relies solely on nineteenth century statistics and totally ignores the possibility of using multiple regression techniques.

[60] A commonly voiced opinion over this development is: "It's about time some kind of control or review system were established."

[61] Licenses have reportedly been cancelled for commission of some felony unrelated to the practice of medicine.

[62] In New York State, for instance, physicians are licensed by the Board of Regents of the Department of Education.

- Does loss prevention "work" either in the sense of reducing occurrences or in reducing the insurance carrier's payout for those incidents which do occur?
- Why do some carriers consider loss prevention activities to be effective within group plans but not with individuals?
- What enables one carrier to direct its loss prevention activities to individuals but precludes other carriers from similar behavior?

F. MAKE MALPRACTICE INSURANCE COMPULSORY

At present, medical malpractice insurance is *de facto* compulsory. Given the existence of malpractice, there is good reason to legislate compulsory malpractice coverage. Such a move would require an addition to the financial responsibility laws requiring every institution and practitioner to either show a certain level of malpractice liability coverage or sufficient personal assets to pay malpractice claims up to this level.

Before instituting such a requirement, it would be necessary to determine the proper level of coverage and whether this level should vary between types of institutions and specialties. The next step would be the development of an appropriate insurance mechanism. Should the medical malpractice insurance market be left to its own devices, or be assumed by the state and/or Federal governement, or should there be a joint private-public arrangement?

Other questions include the limits which would be used to determine the differences in rates between classes. Should the limits be 5/15, 25/75, and should there be any differentiation in rates between classes? Should all extraordinary losses be pooled for all institutions and practitioners by various subsets, or should society pay all extraordinary losses? i.e., the Federal government is the reinsurer? Once malpractice insurance is compulsory, all of these questions are in the domain of public policy.

G. SUMMARY

Unfortunately, problems of malpractice insurance have not attracted much study or attention within the insurance industry. The malpractice area will most likely continue to suffer from neglect because it is virtually beneath the threshold of the industry's visibility. As a sudden collapse of the malpractice insurance market would create a national crisis in health care delivery, it is suggested that these recommendations be brought to the attention of those federal agencies which are interested in problems of health care delivery.

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Appendix A
Individual Studies of Groups Plans

This section contains case studies of three hospital association plans, four state medical society plans, one county medical association plan, and one national specialty society plan. These are presented in the following order:

- Hospital association plans
  - California Hospital Association
  - Pennsylvania Hospital Association
  - Texas Hospital Association
- State medical society plans
  - Florida Medical Association
  - Minnesota Medical Association
  - Medical Society of the State of New York
  - Medical Society of Virginia
- County medical association plan
  - Los Angeles County Medical Association
- National specialty society plan
  - American College of Obstetricians and Gynecologists

California Hospital Association

A. DEVELOPMENT AND IMPLEMENTATION

Credit for the early development and innovation features of the group professional liability program of the California Hospital Association (CHA) belongs primarily with the efforts of Ritz Heerman, then Chairman of the Insurance Council of the American Hospital Association (AHA). The demise of charitable immunity, rising professional liability insurance, and in some instances, cancellation of coverage motivated the first attempt to establish a group program in the late 1940's. Eighteen hospitals entered the program which was administered by a broker and underwritten by two small insurance carriers. A little more than a year elapsed before both carriers were closed as being insolvent. A group workmen's compensation program was developed at the same time, but received stiff insurance industry opposition and was declared illegal by the insurance commissioner. Heerman promptly initiated legislation to change the law and was successful.

By 1953, the situation for California hospitals had become severe. Several hospitals could not purchase professional liability insurance domestically and were forced to turn to the London market. Other hospitals changed carriers yearly to seek better rates or because they were cancelled. Some carriers would write professional liability insurance only if they could write all other lines of hospital insurance. Rates were still rising and one particular hospital was asked to pay $60,000 in premiums, a rate of $300 per bed. Hospital concern mounted and the California Hospital Association through Heerman, began looking for group programs.

Because of past experience, the CHA wanted a large carrier with financial stability to assume the risk. George Walker and Company, a Los Angeles brokerage firm, received a proposal from a large carrier with a retrospective rating basis and penalty premium provision for adverse experience. Heerman believed the rates too low and felt the plan should be on a "pay as you go" basis. He also believed that the workmen's compensation and professional liability programs should be separate. Two days before the meeting for Board approval was scheduled, the carrier backed out. Walker who handled the excess lines for the Farmer's Group negotiated with the carrier on a retrospectively rated program without penalty premiums. The program was approved by the membership and became effective January 1, 1954.

Under the program, Walker and Company became the exclusive broker with no independent agents allowed to place coverage. This stipulation was a significant obstacle to early enrollment efforts as local broker relationships created a rough impasse for placing coverage. However, the concurrent establishment of a group workmen's compensation program gave the Association a compromise incentive. The Association allowed a generous commission for local agents placing a hospital's workmen's compensation, believing that local agents were experienced and competent to service this line of coverage. The professional liability coverage as a distress line was a much more recent and specialized line and the Association felt that centralized servicing was necessary to promote the philosophy behind the plan and to keep administrative costs down. However, in its early years the program found it difficult to convince hospitals to switch their coverage to the group.

At that time the standard policy did not cover the employees of the hospital. Employees named as defendants in a law suit were given "courtesy coverage" by the hospital by which defense counsel was provided and losses were paid by the hospital. Under this provision the employee was asked to sign a letter verifying that the courtesy was given. However, if the employee were named exclusive of the hospital in a suit, no coverage would be provided, only defense counsel. The group plan bound the carrier to cover all employees of the hospital as well as volunteers at no extra rate. The term volunteer was later to be interpreted as including doctors performing committee functions.

The group concept arose from the belief of the CHA that the professional liability problem was an industry problem, not that of an individual hospital. The remainder of this study will discuss the features evolving from this philosophy.

B. CHARACTERISTICS

Since the program's inception, the number of hospitals participating has reached about 400. Potentially, there are some 600 hospitals statewide, but several have insurance under other arrangements, i.e., teaching hospitals, state hospitals, public health hospitals, etc. There is little competition for the program, although occasionally a few hospitals will leave or enter the program. The basic characteristics are:

- Farmers Insurance Group is primary underwriter with several layers of excess coverage being reinsured primarily by Lloyds of London.
- A level premium concept set at a maximum to avoid penalty payments and with excess premiums returned as dividends.
- Assignment of several safety specialists with knowledge of medical practices and hospital operations to inspect facilities and confront professional liability problems.
- A Committee on Insurance to work with the carrier and the hospitals on all matters such as claims, standards of care, and incident reporting.
- An active safety committee within each hospital and development of a claims prevention program.

C. RATES

The Farmers Insurance Group of Los Angeles underwrites the primary coverage, the first $100,000. The amount in excess of $100,000 up to several millions of dollars is reinsured by other carriers, principally Lloyds of London. Retrospective rating is applied only to the first $20,000 of any paid claim. This means that if past loss experience is favorable, dividends may be returned on the premium paid for the first $20,000. Loss experience for the CHA program has not been favorable enough to warrant a dividend. In the event a dividend does accrue it will be distributed among all participating hospitals on a prorata basis.

The method of assessing premiums reflects the philosophy of the program. The traditional approach to rating has been based upon the experience of the particular hospital. The CHA believes that the professional liability problem is an industry problem not an individual hospital problem. In order to get the industry to respond in a cooperative effort, it is necessary to apply a level premium to all hospitals. The effect of individual experience rating is to create an incentive for the individual hospital to concentrate on its own problems. A hospital may not report some incidents or conceal relevant information on an incident for fear of jeopardizing its rates or eligibility. The Association and the carrier believe it is difficult to develop a true individual rate by hospital because of the long tail on malpractice cases. Also, an individual hospital may have several years free of adverse claims experience and then suddenly encounter a flurry of significant losses or one very sizeable claim. Another argument favoring the level premium group concept is that an individually rated hospital when faced with a judgement which may set a precedent for future judgements will not take the risk involved and may attempt to settle the case early. When the risk involved in a test case is shared by every member of the group program, an individual hospital has more incentive to fight risky claims.

The carrier's engineer is the best judge to rate a hospital's potential for liability. However, the consequence of his judgement is extremely important in terms of premium dollars when hospitals are individually rated. Knowing this, the hospital may try to cover areas of exposure which actually defeats the purpose of the engineer's job. There is little incentive for admitting possible safety weaknesses. Again, the level premium avoids this by not penalizing the hospital for needing safety improvement.

The Association after many years of experience has analyzed its statistics on claims and looked at groupings by size, type, and geographical situation, but found no significant differences (except teaching hospitals) upon which to base rates. These results have confirmed the Association's belief in the level premium concept. They feel no basis exists statistically for experience rating. All parties involved with the program believe their initial decision to apply a level premium is the most important factor in the success of their program.

The level premium is based upon three basic rates: a rate per occupied bed-day; a rate per 100 outpatient visits; and a rate for the number of full-time doctors employed by the hospital. Due to the significant increase in recent years of the number of outpatients treated in California hospitals and the improved methods of delivering medical care to these outpatients, the rate for outpatient visits is being analyzed to determine the validity of its development. The rating factor for full-time employed physicians is utilized to distinguish the teaching hospitals which have had a more adverse loss experience.

A deductible provision has been established to administer a minor penalty to hospitals with adverse losses. For each paid loss excluding legal expenses, a $250 deductible is applied. The maximum deductible for any given year is $1,000. It was necessary to place a low limit on the amount of the deductible to avoid a conflict of interest between the hospital and the carrier in litigating a case. The reasoning follows that if a claimant were seeking a judgement of $10,000 and the deductible were the same amount, the carrier would perhaps be inclined to settle at that amount. The carrier would not desire to defend the case and in so doing, raise the potential payoff and the defense expenses whereas early settlement would cost the carrier nothing. Obviously, the hospital would have nothing to lose in defending the case.

D. COMMITTEE ON INSURANCE

The responsibility for monitoring and directly the plan is delegated to the Association's Committee on Insurance which handles all the Association-sponsored insurance programs for its members. The primary concern of this Committee is hospital performance. The criterion for judgement is not the size or frequency of claims, but how the hospital cooperates with the program. This attitude must be predicated upon the basis that if losses occur, the incidents giving rise to these losses are at least partially controllable or avoidable, providing the hospital cooperates.

In the area of underwiting, either the carrier or the Committee can cancel a hospital's coverage. The primary grounds for cancellation is a determination by the Committee that the hospital is unwilling to cooperate with the program by not executing the recommendations offered by the Committee, carrier, or broker. It is the right of the hospital to a hearing before the Committee to air views regarding these matters. In nearly all cases, a solution short of cancellation is arrived at. Nevertheless, the threat of termination is an important regulatory power. Every new hospital in the Association which wishes to participate in the program is automatically covered by the carrier for a probationary period. During this time, a complete survey of the hospital is undertaken by the carrier's engineers. Only when the results of this survey are favorable or the engineer's recommendations are carried out will a policy be issued. The carrier retains the right of making the final underwriting decision, but is bound to consider the judgement of the Committee. There has rarely been an occasion where the two were not in accord on underwriting decisions.

Another responsibility of the Committee lies in the area of rate-making developments. The carrier is required to give full financial disclosure to the Association. By analyzing the statistics made available to it, the Committee can continually negotiate with the carrier on the level of rates.

Disputes do arise over legal counsel, and the Committee has retained the right to disapprove of legal counsel in any given claim situation. The written consent of the hospital is necessary to settle a claim, and the agreement which develops between the hospital and the carrier can be brought by either party to the Committee for a decision which is binding on both.

The reports of incidents and claims enable the Committee to judge their own work. The carrier supplies the Committee periodically on the number and type of incidents which occur and in what hospitals. Trends or patterns which can be seen developing either in a particular hospital or for the program as a whole are given immediate attention. If a particular member hospital has suffered a rash of claims or incidents, the administrator of the hospital, the head of the medical staff, and the chief of the nursing staff are called to discuss these matters.

Incident reporting is one activity which the Committee monitors very closely. Prompt reporting of every incident whether a potential claim or not is one measure of a hospital's cooperation with the program. The Committee usually takes immediate action if a hospital gets lax in its reporting of incidents and the program is quite proud of the short lag time from an occurrence to the time it is reported.

It is essential that the appropriate incentives exist for the hospital to want to report incidents. Before the program began, hospitals were accustomed to the carrier setting up a claims file on nearly every reported incident. This had the effect of building up a claims record when no losses were paid. In the group program, the carrier is required not to establish files or place reserves on any incident as an automatic procedure. Proper investigation must ensue and the potential for a claim must be determined before reserves can be set aside. Another incentive lies in the level premium concept. The hospital realizes that the reporting of incidents, no matter how many, will not change its premium. Incident reporting is essential to the purpose of the entire program. It uncovers minor incidents which may be potentially major claims and it facilitates investigations which are more difficult to perform the longer the time lag.

E. CLAIMS HANDLING

All incidents and claims are reported directly to the carrier. Claims specialists review the incidents and determine those to be investigated along with the claims reported. Farmer's Group has ten claims adjustors whose primary function is to service and investigate claims matters. These adjustors are assigned to particular hospitals and work continually with them. The adjustors also assist on the hospital's claims prevention.

F. CLAIMS PREVENTION

In addition to the role played by the Committee on Insurance in monitoring hospital performance, the carrier is obligated to use part of the premium it receives for safety control activities. Although the amount to be expended by the carrier is not explicitly stated, the Association attempts to maintain a high participation rate and volume premium to justify the carrier's loss prevention program.

The specialists most essential to the process are the safety engineers. The Association is careful to make the distinction between safety control which is adopted toward workmen's compensation losses and safety control dealing with medical procedures. While general liability, brick and mortar safety control is important, the CHA has found that efforts in these areas do not reduce the incidence of professional liability claims. Safety committees do exist in most of the Association's hospitals, but most malpractice occurrences do not fall within their realm.

The Farmer's safety control specialists are experienced with hospital operations as well as medical procedures, and are specifically trained in professional liability problems. These factors are essential for communicating with hospital personnel at all levels.

Besides the initial survey which is undertaken for every new hospital coming into the program, these safety engineers perform periodic inspections of every hospital and will spend as much time as necessary with hospitals displaying particular difficulties. At least once every two years, an extensive inspection of all departments is made as the initial survey is brought up to date. Special visits are sometimes necessary to discuss incident trends or new procedural methods which need to be initiated. By assigning specific hospitals to each engineer, rapport and trust is established between the hospital personnel and the engineer. This is important for both the hospital and the program because the engineer is the primary judge of hospital cooperation toward program objectives. The engineer can determine to the extent to which the hospital exercises self-initiative to police itself. Many times problems are not a matter of dollars to be spent for improvements but motivation of personnel. The approach is to change attitudes not to penalize the hospital.

Considerable education is also a part of the claims prevention effort. Bulletins, seminars, and lectures are all necessary to inform and convince hospitals of the importance of controlling incidents and upgrading the quality of medical care offered by these institutions.

Hospital Association of Pennsylvania

A. DEVELOPMENT AND IMPLEMENTATION

For several decades in most states, non-profit hospitals were protected against liability litigation by statutes under the "charitable immunity" doctrine. New legislation and case law has now removed this shield for many jurisdictions. Hospitals in Pennsylvania lost the defense of charitable immunity in 1965 by Supreme Court decision. Whereas the intent of these reforms was to put hospitals on equal basis with other liable institutions, in actuality it perhaps left hospitals more vulnerable than other corporate defendants. One reason for this is that after several generations of immunity most hospitals were unprepared to cope with liability actions pursued in an aggressive litigation climate. Besides not being defense-minded, insurance costs had not yet become a major budget expense. All this was compounded with the fact that a hospital's clientele, usually in physical and sometimes financial distress, were quicker to retaliate for perceived or imagined wrongs.[1]

The Hospital Association of Pennsylvania held the position even before the Supreme Court decision that hospitals had a moral if not legal responsibility to carry professional liability coverage and, therefore, recommended this protection to its members. In 1962, proceeding with this policy, the idea of a group plan germinated. By offering a group plan to its membership, it would get greater participation. By 1963, an insurance committee was formed to investigate a group plan and Edwards, George, Inc., a Pittsburgh brokerage firm was given the task of finding a carrier. Edwards, George, Inc. had previously warned the Hospital Association of the problem that would ensue once "charitable immunity" was rescinded. At that time the Pennsylvania hospital bed rate was $2 while California had a rate of $25 per bed. The brokers believed the Pennsylvania rate would multiply without the doctrine, but that if the Association get started early enough, a fund could be set up to temporarily postpone a rate increase.

In trying to find a carrier for the plan, the Association had to select a carrier who would not include workmen's compensation as a part of the plan. The Pennsylvania Manufacturers Association, an insurance company operating solely in Pennsylvania, had a major share of workmen's compensation plans of the hospitals. They were able to retain this market because they were direct sellers to insureds and were thus able to offer a 15% lower premium from manual rates. Therefore the Association felt it would undoubtedly be a marketing problem to offer a professional liability plan with workmen's compensation a requirement. The Association also sought a carrier with basic stability, a reputable standing, and one who would not desert the plan when times were difficult. Following these criteria and after reviewing several proposals, Employers' Insurance of Wausau was selected as the carrier. Employers' was primarily a workmen's compensation insurance company, but had entered the professional liability field as early as 1949, when it became the underwriter for the New York State Medical Society group plan, which it still remains today.

In October of 1964, a group plan was announced called a Comprehensive Hospital Liability Policy, covering both professional liability and general liability. To its member hospitals, the Association listed the advantages of the plan as:

1) An opportunity to build reserves before "charitable immunity" was rescinded;
2) Immediate availability of coverage to all its members—even if the doctrine was revoked;
3) Stability of market—the plan was intended as a long term commitment by both parties;
4) By group participation, a lid could possibly be kept on rates.

Initially, two hospitals joined the plan; however, in March of 1965, when the Supreme Court rendered its decision, within a week of the decision thirty hospitals scrambled to join the plan. One-third of all Pennsylvania hospitals had no professional liability coverage at all when the court handed down its decision.

After three years of operation, the loss experience among Pennsylvania hospitals was poor. The carrier was seriously considering dropping the entire program due to losses paid on claims and money held in reserve for future claims. Negotiations were held between the broker, Marsh and McClennan who had acquired Edwards, George, Inc., the carrier and the Association during which Employers' stated that it would retain the plan if workmen's compensation became a required part of the group package. The company held that since 50 percent of its business was in workmen's compensation and this was their major line, it was natural to include this as part of their package to any client. Perhaps more important, workmen's compensation is an established group line of business with fairly predictable experience trends. By including this coverage with the comprehensive liability plan, stability could be added to the entire program. Additionally, it was felt that combined service on audits, safety efforts and claims service would save operating expense. Whether perceived or real, these advantages were reluctantly accepted by the Association and in 1968 when the anniversary date of each hospital's workmen's compensation came due, they had to switch their coverage to Employers' or forfeit their professional and general liability policy.

Obviously, this brought an adverse reaction from insured hospitals who now had the choice of either foregoing dividends and lower rates on their workmen's compensation with the Pennsylvania Manufacturers'Association or seeking malpractice liability coverage with another carrier. Most all the hospitals stayed in the plan with its new requirement. Why other carriers did not seize the opportunity to get into the Pennsylvania market is not known. Hospitals found available coverage was scarce and at a prohibitive rate. The Pennsylvania Manufacturers' Association at that time did initiate a malpractice program but they insured less than 15 hospitals and these were the better risks. It can only be surmised that the loss experience of most hospitals was such that malpractice insurers were unwilling to offer coverage.

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[1] Liability Insurance Protection for members of the Hospital Association of Pennsylvania, Employer's Insurance of Wausau, p. 3.

One major carrier, however, did make a serious proposal to underwrite the Association's group plan. The carrier proposed that if the Association could cut down on legal costs in litigation, it would accept the program. This could be accomplished, the carrier believed, if the Association could get the Pennsylvania State Medical Society to endorse its plan for their physicians. This would allow the carrier to use the same attorneys in hospital suits naming individual doctors. Savings would also accrue by using the same claims department for investigation. The magnitude of these savings is not known at this time. However, the Hospital Association while waiting for its board to endorse the proposal, was informed that the carrier had instituted similar negotiations with the Medical Society and would become the Society-sponsored carrier for physicians. The Association, shaken by this breach of trust in negotiations, declined the offer. Nevertheless, the carrier still remains a serious competitive threat to the current group plan and has submitted recent proposals.

B. PLAN CHARACTERISTICS AND OPERATION

Any hospital which is a member of the Pennsylvania Hospital Association may participate in the group program. Currently there are approximately 100 hospitals enrolled in the comprehensive liability program–about 1/3 of those eligible to participate. Originally, Employers' would not insure osteopathic hospitals in the plan because of anticipated high loss experience. There are some twenty of these hospitals in Pennsylvania, most of which are members of the Association. The Association made it clear to Employers' early in the program that since membership in the Association was the criterion for eligibility, osteopathic hospitals must be included in the plan. Employers' agreed to insure them.

There are two primary causes for hospitals not participating in the plan. The first can be attributed to hospital affiliation with a local broker or agent who has maintained a strong relationship with the hospital over the years and who may have board of trustees support. Several hospitals have a trustee who is an insurance broker and handles their insurance. Prior to 1972, the state's criminal code stated that no trustee of a hospital receiving state funds could serve the hospital and continue to sell goods and commodities to that hospital. However, this did not include services such as insurance and therefore, these brokers would place the hospital's insurance through their firms. Local broker affiliation is still a major deterrent, even though the criminal code has been altered to include services. The Hospital Association in an attempt to cope with the roblem offered to split the commission between the broker and the local agent. In one particular case, a proposal to split commissions was offered to a hospital. This proposal was rejected even though the bid was $16,000 less than the competitor's plan. Many hospitals pay substantially higher premiums to retain their own broker.

The second reason for non-participation is due to the availability of a lower rate with another carrier. This usually occurs when a hospital has good loss experience and is considered a good risk. This competitive practice is sometimes called "cream skimming" and occurs frequently in the malpractice market for hospitals in Pennsylvania. Unfortunately, the results of both these situations for the Association is that several of those hospitals participating in the group plan are poor risks which would not be able to obtain coverage elsewhere. This is an important advantage of the group plan, to make coverage available to all members.

The basic policy which is issued individually to each hospital is a comprehensive liability policy. It has three areas of liability coverage: personal injury, property damage, and hospital professional (malpractice). The professional liability coverage applies to any injury to a person arising from the rendering of professional services such as: medical, surgical, dental, or nursing treatment, dispensing or furnishing of drugs and supplies, performing post-mortem examinations, or service by a member of a professional board or committee of the hospital. The company has the right to defend any suit and to make investigations or settle the claim. However, the settlement shall be with the written consent of the hospital. Either party has the right to submit a disagreement on settlement to arbitration with the results binding to both parties. The policy states that any officer, administrator, board member, supervisor, employee, student, or volunteer worker while acting in the scope of his duties shall be insured. Several physicians such as radiologists or anesthesiologists are partially employed by the hospital while having an outside private practice. In these cases, if a claim occurs while the physician is on hospital duty he is covered by the plan.

Each policy is renewable on a yearly basis and may be cancelled with 30 day written notice by the company. However, 90 day written notice is required for termination of the entire group program. Since the inception of the plan, no hospital has been refused coverage. Nevertheless, the company can put pressure upon the hospital by raising its rate so that the premium may become prohibitive and the hospital will be forced to drop it.

Two other policy features were added within the last two years. The insurance coverage under the policy applies only to claims made against the insured during the policy period. If the policy is cancelled or not renewed, coverage will apply to claims made during the 36 months immediately following the expiration date. The hospital may purchase optional coverage to extend this period for claims ("buy the tail"). The carrier's rationale concerning this "claims made" feature is not to restrict coverage, but to force the hospital to report incidents as they occur and to lessen loading factors for prior years within the rate structure.

The second new policy provision pertains to dividend participation. Under this provision, the insured hospitals through the Association will share in any premium remaining after claims are paid, reserves are established, and the company's cost of doing business (retention factor) is covered. Dividends will be distributed equitably in relation to premium input. Therefore, a hospital with a low premium will receive a proportionately lower dividend. The Association because of loss experience does not anticipate dividends in the near future.

C. MARKETING EFFORT

Marsh and McClennan as insurance brokers have complete responsibility for marketing the plan. Employers' deals directly with the broker except in the area of claims and safety services where the company works with the individual hospitals. Employers' has printed a booklet describing their liability protection insurance. Marsh and McClennan has also printed a brochure covering all group plans including professional liability for the Association. The broker sends letters to all hospital administrators introducing and describing the plan. When the renewal date for a hospital's liability coverage approaches, Marsh and McClennan will contact the hospital and offer a bid. These bids are developed by underwriters at Employers' home office in Wausau, Wisconsin. The company as underwriter has the final decision for eligibility in the program and determination of the premium. The Association lends support to this operation by continually describing the plan in its monthly bulletins together with informal discussion with administrators or trustees at Association meetings. The Association's role in the marketing process is little more than as the endorsing organization.

D. RATING FEATURES

The current Employers' policy provides minimum basic limits of $300/1,000,000 for professional liability. If a hospital feels this is inadequate coverage it may tailor its protection in several ways. Limits can be raised, protection can be extended to include professional and technical personnel not otherwise covered, or excess liability protection under umbrella coverage may be obtained at an additional charge.

Employers' has developed a rating program for the Hospital Association which is submitted to the Pennsylvania Insurance Department for approval. These rates are applied to all hospitals in the plan. For any individual hospital, the premium consists of the basic rate which is then adjusted to reflect the loss experience of the hospital. Typically, the better the loss experience a hospital maintains, the lower will be its premium in relation to a hospital of comparable size and similar characteristics with poorer experience.

The factors which are included in rate determination are: a flat rate per average daily occupied bed, a rate per 100 outpatient visits, the number of full-time physicians employed by the hospital, and the loss experience and reserve status of the hospital. A basic rate is applied to all hospitals for every factor except the loss experience for which the company adjusts the basic rate. The bed rate in Pennsylvania has increased dramatically since 1965. At that time before the Supreme Court decision the rate was $2 per bed for $5/15,000 limits. In 1967, it had jumped to $10 and in 1972 the bed rate was $15. The experience factor has served to promote competition in the rate market especially for hospitals with better loss experience. Experience rating gives Employers' the opportunity to confront the phenomenon of "cream skimming" mentioned earlier.

E. CLAIMS SERVICE

The claims relationship with the hospital is individually maintained by field representatives subject to direction from Employers' regional office in Philadelphia. The regional office has a special malpractice claims unit consisting of a manager, several clerks and 7 field adjustors who service the hospitals primarily on malpractice claims.

Employers' maintains its own legal staff; however, it usually contracts with local attorneys experienced in malpractice suits to handle cases.

The whole process of claims service begins when an incident occurs. The hospital fills out an incident report form and sends it directly to the regional office. The claims department in Philadelphia receives these incident reports, and an initial review is made of all incoming reports to determine the seriousness of the incident. If the claims department feels the incident is serious enough to constitute a potential claim or suit, then a file is set up and a reserve against potential losses is established. All other incident reports are filed for future action.

When a claim is made to a hospital it is reported immediately to the regional office which sets up an individual file and determines an appropriate loss reserve for that claim. Loss reserves are an important factor in the calculation of current year premiums. The changing of reserve status is common practice as more is learned about a particular claim; however, the insured is usually not notified of the changes and therefore, is not acquainted with the reasoning. The area of loss reserves, because it requires judgement by claims adjustors, has been a mystery to policyholders and has often caused mistrust toward the carriers' handling of these claims and ultimate premium determination.

F. LOSS PREVENTION

A copy of the incident report is also sent by the hospital to the home office of Employers' in Wausau. The product management and safety department receives it, and a nurse within this department has the full-time job of coding each report of the data file on a computer. The data consists of which hospital reports the incidents, what department it occurs in, the nature of the incident, and pertinent facts about the injured person, if someone was injured. Periodically an entire tab is run on all insured hospitals listing every reported incident. The home office staff reviews these compiled data and analyzes them for trends in accident occurrence and potential safety hazards. A copy of this tab is also sent to the regional office and the Hospital Association. The regional office has two full-time nurses and several safety consultants or engineers who also review the tab, but especially look at an individual hospital's incidence record. When areas of frequent occurrence or hazardous conditions exist, a consultant and nurse will visit with the hospital administrator and staff to discuss the trends and what can be done to improve or eliminate potential incidents. The ultimate goal, of course, is to reduce the number of incidents and their seriousness by removing the conditions that cause them. This should improve loss experience and therefore, reduce rates.

Initially, hospitals were reluctant to report incidents because they believed the company would immediately set up claim reserves. This fear may be justified; however, the carrier wants incidents reported immediately for claims and loss control purposes so they can determine areas of needed improvement. It is anticipated that 50,000 incidents will be reported in 1972 and it is evident that hospitals are now making efforts to report every incident. Prompt communication of loss reserve status and the reasons for changes are the means by which the carrier can establish the integrity of the reporting system.

The safety and loss control program has several additional features. The carrier and Association both constantly encourage member hospitals to establish a safety committee or professional liability committee with representatives from nursing service, administration and medical staff to review loss control performance and effect improvements. The company's consultants also advise administration of safety and job training methods and encourages special training programs such as seminars, conferences, and courses. Employers' provides record forms, evaluation criteria, posters, literature and films to assist in the function of these training programs.

G. ASSOCIATION'S ROLE AND SELF-REGULATION

As discussed previously, the Association's role is that of an endorsing organization. Through its committee on insurance and safety the Association is able to negotiate changes in the policy and to issue monthly bulletins informing members of availability of coverage and loss prevention activities.

However, this role has been minimal at best in the area of professional liability as the committee has responsibility for all the Association's insurance programs. Recently, the Association hired a person who will spend his entire time on insurance matters. Several plans are underway or being discussed to increase the Association's involvement in the plan's operation. The Association hopes to be able to maintain adequate records of insured hospitals, to participate in rate determination and to monitor hospital efforts in safety performance. No attempt has been made in the past by the Association to involve themselves in claims settlement. No formal group exists to review claims by the Association, as this matter is left entirely to the carrier and the individual hospital.

There is a proposal for a medical-legal, hospital panel designed hopefully to cut down the number of claims, especially nonmeritorious claims, but the Association feels this panel is a long way from coming into being. The Association sees the responsibility of peer review belonging within the hospital and encourages hospitals to establish panels within their organization to review claims and loss control.

Texas Hospital Association

A. DEVELOPMENT AND IMPLEMENTATION

The Committee on Insurance of the Texas Hospital Association (THA) was organized in December of 1965. The Committee was and still is composed of administrators of member hospitals who were appointed originally with the responsibility of making recommendations to the THA regarding insurance programs. Through the years, the committee has monitored the operation of the shared insurance programs which the Association undertook as a result of the Committee's investigations.

After a year of study, in which questionnaires were sent to every member hospital to survey their insurance problems and needs, the committee proposed that shared insurance programs (group plans with association sponsorship) be made available to its members. The Committee then analyzed the philosophy and efforts of other state associations with regard to their shared insurance programs. They surmised that their own programs's success or failure would be in direct proportion to the efforts of the THA itself.

With this in mind, they set out to find a managing agency to set up the entire program. Criteria for selection of the agency were drawn up and proposals were solicited. The Boon-Chapman Agency of Austin, Texas was selected because of its proximity to the THA, its statewide coverage, and its expertise in the insurance field. The agency agreed to act as the managing firm (Texas law prohibits insurance brokering) to both design and implement the insurance programs. They also proposed that their agents act as representatives of the association with the numerous independent agents in Texas.

An important development was taking place at this time within the courts of Texas. The doctrine of "charitable immunity" which had prevailed for several decades in Texas was weakening as a defense for liability litigation. Although no law defines this doctrine, clear warning was given in State Supreme Court decisions regarding a hospital's responsibility in liability cases. It soon became evident that hospitals could no longer assume protection against claims and consequently, professional liability coverage became a necessity.

The first discussion of a professional liability program occurred in January, 1967 with the committee on insurance and the agency along with a representative of the Argonaut Insurance Company of California participating. Prior to this meeting, Boon-Chapman had contacted every major professional liability carrier in the country and had asked that they submit formal proposals. The competing carriers were narrowed to two major insurers—Argonaut and the Insurance Company of North America.

The professional liability situation in Texas at the time of this meeting consisted of a few carriers in the market and active in competition. There were several hospitals that where shielded by the doctrine of "charitable immunity" and would have had difficulty obtaining coverage if this protection was abolished. Of the hospitals which had coverage, liability limits were inadequate and very few had umbrella coverage.

The insurance committee believed that a sponsored group plan would provide availability to every member hospital at limits which were commensurate with the hospital's potential liability. The committee also believed that provision of loss control through safety programs would not only yield safer hospitals with better quality care, but would ultimately reduce claims and hopefully rates.

Selection of the carrier was based on several characteristics the committee and agency felt vital. These included:

1) Sound financial base;
2) Long standing in professional liability coverage;
3) Willingness to insure any member of the association;
4) Expertise in loss prevention and safety control programs;
5) Reasonable retention factor;
6) Association control of refunds.

Argonaut exhibited adequacy in all these areas and was a particularly stable professional liability underwriter, having had some 14 hospital association plans at that time without ever abandoning a plan. After several meetings with the THA, Argonaut was selected to be the carrier.

The initial plan provided new coverage; i.e., included coverage for all employees, and had lower rates than existed before. Some question was raised concerning a common expiration date and the retention factor. Argonaut was willing to renew all policies on July 1 of each year and stated that they estimated a retention percentage of 34%. This factor contained no variables; therefore, low participation in the plan's early development would not be penalized.

The Argonaut does not retain a selling force and therefore, individual hospital policies are written by independent agents. Boon-Chapman through the state's agents' association announed the plan. In addition, letters were sent to all member hospitals introducing the new plan and its carrier. After six months of operation, 30 hospitals had placed their coverage through the plan. Initially, strong resistance was encountered with the local agents who had established loyalties with other professional liability underwriters. This remains a major obstacle to increased participation in the program today. Faced with this resistance, Boon-Chapman decided to go directly to the hospital administrators and explain the program in detail. In each case, the hospital was told that if it wished to participate, its local agent could write the policy and place it with Argonaut. However, local agents still resented the fact that they had not been the prime motivator in selling the coverage and many wanted to retain the higher commission offered by other carriers (Argonaut offers 10% of the premium as selling commission). Boon-Chapman has placed a few policies themselves for which they receive the 10% along with their retention fee of 2½% on all policies sold. By 1969, the marketing program was beginning to take hold and 82 hospitals were members of the THA sponsored program.

Under the Texas Tort Claims Act of January 1, 1970, governmental immunity was not eliminated but limited to liability amounts of $100/300,000. Therefore, within the THA program governmental hospitals are insured as well as governmental functions within proprietary hospitals. For governmental hospitals and for other insureds in the program, the carrier and Association recommend that the workmen's compensation line of coverage also be purchased through Argonaut. This is especially true for small hospitals where the premium income from the professional liability line is minimal and insufficient to cover the risk. The insuring of both lines with Argonaut also aids in settling of claims where it is difficult to determine in which coverage liability falls.

B. CHARACTERISTICS

Eligibility into the Texas Hospital Association professional liability group plan is based on two requirements. First, the hospital must be a member of the THA. Second, the member hospital must agree to accept and cooperate in Argonaut's safety program. This second requirement is particularly important because the Association and company both feel that cooperation in the safety program is the only way to control losses. Several hospitals once they are in the program become lax in implementing the suggestions of Argonaut's engineering staff. These hospitals often use the excuse that the needed improvements are too costly. A few of these hospitals decided to leave the plan, only to find availability difficult. This is especially true when the potential safety hazards of a hospital are evident and even if they become insured, the premium is extremely high. Usually after encountering this situation, the hospital will decide to comply with the recommended changes in order to get coverage in the program.

Presently, there are between 160-170 member hospitals in the plan. This represents about 40 percent of hospitals eligible for coverage. The principal reasons for non-participation: competing individual carriers write hospitals which are considered the better risks; and local agents resist placing policies with the group plan.

The existence of a group plan actually serves to promote the practice of "cream skimming". Originally, all individual policies had a common expiration date and Argonaut would quote the advised manual rate developed by ISO. The effect was that competing companies in Texas were able to determine the rate Argonaut would use for an individual hospital and develop a rate just under Argonaut's. They also knew when each policy would be renewed and could plan exactly when to submit their bid. Many times these competitors would be allowed by the hospital to rebid so that the hospital could get the lowest rate possible.

To prevent this process from occurring, Argonaut did two things. The renewal date for every hospital was staggered and they incorporated experience rating. That eliminated two advantages previously given to competitors.

With experience rating Argonaut was able to cut rates on hospitals with good loss experience and therefore became competitive. They also stopped the rebid, since this was proving to be too costly. As a result of these changes, Argonaut is beginning to secure coverage with some of the larger, better risk hospitals.

The basic policy provides for not only professional liability coverage but general liability as well. This is a common characteristic of all Argonaut's hospital group plans. The required limits for all members of the plan are $250,000 per claim, $500,00 per incident. In addition, umbrella coverage is available through Argonaut with liability limits up to 5 million. Governmental hospitals in the plan are not required to carry more than $100,000/300,000 liability limits, and do need to carry property damage insurance due to the Texas Tort Claims Act. This Act, effective January 1, 1970 eliminated governmental immunity in restricted areas, but did not extend to property damage or commercial lawsuits.

Another provision in the plan established a mechanism called a "rolling dividend." This dividend feature is applied by the company back to the first policy year. The retention factor and paid losses are subtracted from the total earned premium and any excess is given back to the members as dividends. This participation arrangement has fluctuated as to its yield for several years and no dividends have been paid to date, although the Association expects some in the near future. The philosophy of Argonaut as explained to the THA is that underwriting profits should accrue to the policyholder and investment income or profit to the stockholders.

A corollary provision instituted in the plan was called the "stop loss" feature. Under this stipulation, any claim payment in excess of $25/75,000 liability limits will not be considered in the computation of dividends. This implies that dividends can only be earned on the premium relating to these liability limits. In effect, this feature would prohibit the occurrence of one or several large claims from being considered in the dividend calculation for the entire group program. However, this feature does not apply to experience rating of individual hospitals.

C. RATES

Since the plan's inception, Argonaut has used the manual rates developed for Texas by the ISO in New York. Texas law does not require use of these rates, so in effect, they are merely advisory. In 1970, the ISO basic rate per bed for Texas for $100/300,000 limits was $32 for non-profit hospitals. In 1972 this rate was $83 per bed for the same limits. Faced with this dramatic increase in rates, the THA approached Argonaut with the idea of allowing a percentage reduction in rate for hospitals with good loss experience while surcharging those with unfavorable experience. This concept of experience rating was applied to the Texas plan in July, 1971. This new rating basis had the immediate effect of making the group plan more competitive with policies of other companies in underwriting large hospitals.

Factors which combine to provide a premium for an individual hospital include: the per bed rate; the occupancy rate; a rate per 100 outpatient visits (10% of bed rate); experience rating; perceived attitude of hospital management; and blood bank requirements.

Depending upon the state and its statutes, hospitals may either offer blood as a service or the patient is charged for the blood he needs. The insurance carrier will apply a charge for insuring the risk of providing blood to a patient. The most commonly recognized liability with blood banks is the problem of disease transferred through blood transfusions, particularly hepatitis. This constitutes a large risk exposure for the hospital and potential liability must be covered in the professional liability policy.

Experience rating is an important variable factor in premium determination. Each year before renewal the company looks at each individual hospital's loss experienee going back to the first year the policy was in force. The number of claims, those paid and those still open, along with reported incidents and reserves set aside are analyzed. From this analysis, the underwriter determines whether a credit or debit should be applied to the basic rate for the hospital. The actual calculation of this adjustment is not clearly understood by the hospitals or the association, but it is felt that this basis of rating provides an incentive to the hospital for cooperating with the safety program of Argonaut and aids in making the hospital's management conscious of loss control. As mentioned before, it also provides the carrier with the opportunity of competitive bidding on better risk hospitals.

The company's policy on loss reserves plays a large role in the determination of the hospital's experience. Again there is a lack of understanding of how the company establishes these reserves. The hospitals do not have the knowledge nor the expertise to review this process. They will question why a certain amount is set aside, how long it is left there, and who should get the income earned from its investment. The claims adjustor's experience and expertise are decisive.

Another variable factor is the underwriter's perception of the attitude of hospital management. Considered in this evaluation is the total operation of the hospital, the state of its physical plant, supply of modern equipment and conveniences, surgical procedures, extent of participation in loss control activities, and status of its accreditation. This determination is closely linked with Argonaut's safety program. After annual inspection by the company's engineers, a list of deficiencies is supplied to the hospital for improvement. The extent to which these suggestions are carried out and the time it takes for management to undertake them is of prime importance. The approval of the Joint Commission on Accreditation is also vital for the hospital to receive a favorable rating. Lack of accreditation may be sufficient reason for the carrier not writing a policy at all. The subjective evaluation of the underwriter based on evidence he has collected determines the impact of the factor on the rate.

The retention factor applied by the carrier for administering and insuring the group plan is 34 percent. This factor includes state tax, loss adjustment, general administration, agency fees, commissions, and profit. There have been no negotiations to lower this factor.

D. LOSS CONTROL AND SAFETY PROGRAM

Loss control is the one aspect of the plan that the Texas Hospital Association feels is most important. They believe success in this effort will reap benefits in other aspects of the plan especially lower premium rates. The key to establishing loss control is the safety program developed by the Argonaut. This program was one of the major selection criteria and the principal reason Argonaut was selected as the carrier.

Loss control begins when a hospital is considering a policy under the group plan. Either Boon-Chapman or Argonaut will notify the carrier's state offices in Dallas or Houston to send out engineers to undertake a thorough investigation of the hospital not only for physical defects, but its operating procedures. A check is also made to be sure the hospital has Joint Commission on Accreditation approval. Any deficiencies that are uncovered by this investigation are recorded and submitted to the hospital. The ability of the hospital to make the necessary improvements and the willingness of the management to effect the Argonaut's safety program become the prerequisite for eligibility in the insurance program.

Every year the company's engineers visit each hospital to determine its safety status. Again deficiencies are reported and one copy is sent to the hospital and one to the agent. It is the responsiblity of the agent to talk with the hospital, clearly explain what needs to be done, and to make certain that it gets done in a reasonable amount of time. However, many times the agent does not render this service and the status may remain unchanged or the improvements are carried out without the company being aware of it. This is when the association acts in its role as liaison. The insurance administrator for the Association will receive a letter from Argonaut stating that help is needed in getting the recommendations implemented. The administrator will then call the hospital and determine the status of the improvement. If nothing has been done, a warning is given that renewal of the professional liability coverage is in jeopardy. This process has not always worked smoothly. Argonaut a few years ago was not following up on its own suggestions, but after meeting with the association, company enactment of this service was improved. Periodic review of a hospital is usually dependent upon premium size or size of the hospital (number of beds). Another problem which developed involved the engineers not speaking with the appropriate persons in the hospital. Argonaut soon found out that management red tape in the hospital held the process back. Many times the Association would have to meet with the hospital administrator or board to get the job done. In addition, each hospital is constantly encouraged by the Association and company to convene a safety committee which meets monthly and provides monthly reports to the Dallas or Houston offices. The carrier furnishes educational material, posters, bulletins, and some training seminars in order to make the hospital management and staff safety conscious.

The claims service provided by Argonaut is also involved in loss control. The claims units for Texas are in the Dallas and Houston offices. All incident reports and claims actions are reviewed and investigated by them. Loss reserves may be established on cases with loss potential. The company and association receive reports on all incidents and their causes. This information aids in developing trend data and educates the engineers to pay special attention to these areas in their inspections.

Once a claim has been made against an insured, a local attorney is hired by the carrier to defend the case with the benefit of additional advice from company attorneys. The settlement of claims is accomplished solely through the carrier and the insured hospital. Of course, the hospital must provide written consent before the company can close a case.

E. ASSOCIATION'S INVOLVEMENT

The Texas Hospital Association through its committee on insurance, its designated agent Boon-Chapman, and its full-time insurance administrator, is able to exercise considerable control over most aspects of the group plan. This participation extends both to the carrier and the individual hospitals.

The insurance committee acts as the appeal board for the hospitals, reviewing cases where cancellation may be imminent or eligibility questionable. The agency acts as a buffer with the carrier in negotiating policy conditions and changes in the rate structure. In addition, the agency is the key promoter of the plan, acting as intermediary in contact with independent agents. It also has the obligation to be actively on the lookout for new carriers with better proposals.

The THA provides a market for Texas hospitals through its group plan. It also provides competition, which may not only yield lower rates, but improved engineering programs. The association feels that through the efforts of their plan, hospitals are becoming more aware of the importance of loss control and are looking more at the services they are obtaining rather than just the cost of their professional liability coverage. The Association provides a preliminary survey for hospitals trying to obtain Joint

Committee accreditation. This two-day dry run survey gives the administrator the leverage to argue with the Board of Trustees for funds used for maintenance, modernization, and safety purposes. The results of this service will hopefully yield a more favorable rate from the carrier and will offer some loss control.

The THA is well aware of the areas it needs to get more involved in. It has been critical of the carriers' loss reserve practices and would like to participate more in their determination. Also, the Association believes the ISO rate base for Texas is reflective of a national data base rather than Texas experience alone. The attorney for the Association is actively involved in promoting legislation or amending current statutes which will most benefit the professional liability situation in Texas.

Florida Medical Association

A. INTRODUCTION

The Florida Medical Association (FMA) first developed and sponsored a professional liability group program in late 1961, underwritten by the Employers Fire Insurance Company. In June of 1972, the FMA was formally notified that the Employers would terminate the group plan on January 1, 1973 due to excessive losses. It is estimated that Employers has paid out some $12 million in excess of earned premiums during the life of the plan, and is, of course, still responsible for future claims made during this period.

On October 1, 1972, the FMA announced to its members the new sponsored professional liability group program which was executed with the Argonaut Insurance Company and approved by the Board of Governors.

The following study will describe the operation of the former plan with Employers and identify the features of the new program to begin in 1973. For reasons of continuity and comparison, both plans will be discussed under each subheading.

B. DEVELOPMENT AND IMPLEMENTATION

As early as 1959, efforts were being made by the FMA to secure a group plan for professional liability for its members. Mr. Leyton Hunter, President of the London Agency of Atlanta, Georgia, was formerly with Marsh and McClennan and worked diligently for several years trying to interest a carrier into accepting the Florida physicians under a group plan. Dr. Samuel Day, President of the FMA at this time, and a few interested physicians spoke with several insurance agents and companies but found no party willing to undertake a program alone. It was the desire of these people to obtain group coverage for the FMA members so that claims handling could be facilitated and improved, statistics could be recorded and made readily available, and defenses could be strengthened through advisory committee activities.[2] Also, at this time, the available market to doctors for professional liability insurance was limited. Premiums were rising rapidly in all categories and the high loss experience of Dade and Broward Counties was making it difficult for doctors to obtain coverage.

Mr. Hunter left Marsh and McClennan and together with Dr. Day and several physicans persisted in seeking a carrier. A program was finally developed which the

Table A-1. PROFESSIONAL LIABILITY DATA FOR TEXAS HOSPITAL ASSOCIATION FOR YEARS 1967-1971[2]

	1967	1968	1969	1970	1971
Premiums	48,257	167,353	371,006	896,013	924,613
Claims	19,691	233,245	34,118	27,895	4,182
Loss Ratio	40.8%	139.4%	9.2%	3.1%	0.5%
Reserves	9,000	62,000	428,400	343,100	179,400
Reserve Ratio	18.7%	37.0%	115.5%	38.3%	19.4%
IBNR[1] Ratio	0%	4%	8%	30%	55.0%
Institutions	41	69	124	121	117
Total Loss and Reserve Ratio	59.5%	180.4%	132.7%	71.4%	79.9%

[1] Reserves for incurred but not reported claims.

[2] General and Professional Liability Data for 1971 has been grouped under Professional Liability Table furnished by Texas Hospital Association.

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[2] U.S. Department of Health, Education, and Welfare, *Hearings*, before the Secretary's Commission on Medical Malpractice, New Orleans, Louisiana, January 29, 1972, Statement of Dr. Samuel M. Day.

Carolina Casualty Company and the Employers Fire Insurance Company were willing to underwrite. Employers was the primary underwriter with Carolina Casualty the issuing company and the Employers Surplus Lines Company the reinsurer. Under their agreement, Employers would adjust claims and service the plan while Carolina would serve as issuer and would be billed ten percent of the losses. The arrangement was not ideal with respect to stability, but a market was provided and the foundation for a group plan was set.

There were also two intermediary parties for the FMA. Marsh and McClennan acted as brokers and provided the selling force and marketing for the program. The London Agency in Atlanta provided the administrative and management expertise for the plan. The Agency developed and maintained a sophisticated set of statistical data on all insured physicians and claims activity. These data became an important factor in securing a new carrier for the FMA. The London Agency also shared some underwriting responsibilities with the company. Marsh and McClennan would contact a potential insured and send the completed application to the London Agency for initial underwriting clearance. The carrier would then receive the application for final acceptance and premium determination.

The program was established with an understanding between the FMA and the insurance carriers as to the responsibilities of each and an understanding as to the procedures to be followed in the discharge of these responsibilities. These areas of understanding were as follows:[3]

1. *Stability*—Any company considering this program should be willing to undertake it on the basis that it will be continued for at least five years.
2. *Rating*—The program is expected to continue self-rating on the basis of loss experience.
3. *Statistical Information*—The FMA will be supplied statistical information, not less than annually, as to premiums and losses, program participation, and such other data of interest.
4. *Underwriting Information*—The FMA will make available to the company any information from any source available to the FMA which will assist the company in proper and equitable underwriting.
5. *Education*—All involved are to cooperate in a program to be spear-headed by FMA to educate the membership as to claims prevention and other matters relating to insurance.
6. *Claims Defense*—Non-meritorious claims are to be vigorously contested by the company. Indefensible claims are to be disposed of as expeditiously and as economically as is possible.
7. *Claims Assistance–FMA*—The FMA will afford to the company advice and assistance in the evaluation of claims and the determination of "defensibility," and will further assist in the procurement of expert witnesses for defense from within or outside the FMA membership.
8. *Centralized Claims Defense*—The responsibility for claims defense and claims evaluation should be centralized within the insurance company, and to the degree possible also centralized with respect to defense counsel to attain the maximum benefits thus available through experience.
9. *Claims Coordination*—The FMA shall be informed of claims as they arise. The company shall utilize the committee facilities of FMA under those circumstances when such facilities can contribute to improved claims defense.
10. *Underwriting Decisions–General*—It is understood that the final underwriting decision with respect to an individual physician rests with the company, but the company will be expected to:
    a. Refer declinations or desired terminations to FMA for committee evaluation of the circumstances. Such referral arrangement shall be supported by a "release" or permit clause in the application of the individual doctor.
    b. Give due consideration to the findings of such committee.
    c. Allow ample time for committee evaluation before action is taken to terminate insurance unless the circumstances are such as to positively and unquestionably classify the physician as an eminent threat to the insurance program in which event FMA shall be so notified.
    d. Make every effort to provide insurance for those members not considered fully standard as to eligibility by use of increased premiums, or as a last resort, reduced limits of liability.
    e. Consider any request of FMA to terminate insurance of a member for proper cause.

    The FMA will support the company with respect to underwriting decisions involving physicians who are judged to represent a serious economic threat to the program.
11. *Underwriting Decisions–New Applicants*—Because of the periodic influx of new applicants into Florida who are just starting practice, it is necessary that a binding arrangement be established so that these doctors can be immediately insured on receipt of application. Otherwise, they may be lost to other insurance markets.
12. *Changes*—The FMA shall be advised well in advance as to desired changes with respect to premium level, policy wording, or underwriting practice, and no such changes shall be made without the endorsement of the FMA.
13. *Agency Sources*—The current program is handled on the basis that the individual physician can place his insurance with his Florida agent of choice. This system shall be continued as a necessary means of maintaining participation of the membership.

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[3] Florida Medical Association, Professional Liability Insurance Program, July 5, 1972, pp. 3-4.

14. *Termination*—In the event of a decision by the company to discontinue the underwriting of the entire program, at least six months' written notice prior to the January 1 anniversary date shall be given to FMA. Should FMA decide to transfer the program to another insurance company, they, likewise, will give six months written notice, and the company shall not interfere in any way with orderly transfer of the program.

The plan was not officially in operation until January of 1963 when 390 Physicians were insured at an average rate of $167. The major competitors to the Association's plan were Medical Protective of Indiana, St. Paul Insurance Company, and Employers' Insurance of Wausau. These companies wrote a majority of doctors in Florida, but would not accept the group operation because they were wary of Dade and Broward Counties and a group plan would necessitate their accepting risks in these two counties. Participation grew slowly but steadily and in 1965, 738 physicians were covered by the plan. In 1966, the FMA was able to increase their insureds to 1,250 by allowing any independent agent to place coverage through Employers. Prior to this, Marsh and MClennan were the sole selling agents for all of Florida. A probable reason for low participation in the early years was due to the relationship which had developed between individual physicians and their personal insurance agents. However, the new stipulation opened the selling market to all independent agents and thus gave doctors access to Association coverage without forcing them to breach longstanding relationships.

In 1968, Medical Protective Company, then the largest individual carrier and competitor of the FMA plan in Florida, withdrew from the professional liability market in Florida leaving approximately 1,500 physicians without coverage. The Association's plan was able to cover most of these insureds and by the end of 1971, about 4,600 physicians were enrolled in the group plan. During this period the Employers Fire Insurance Company was purchased by the Commercial Union Assurance Group of London, England.

Even with that broad base, the program overall developed a substantial underwriting loss. This loss came about principally from a lag in requesting premium increases sufficient to cover anticipated losses. Despite drastic increases of premiums in recent years, Employers decided to abandon the FMA group plan. Earlier indications were given by the Commercial Union Group who decided to steadily pull out of the professional liability market. Along with Florida, Employers also terminated with Illinois.

The six months notice given by Employers as agreed upon in the original negotiations gave the FMA little time to secure a new carrier. In the last ten years, 26 companies have abandoned the Florida market. The search for a new carrier was handled by the London Agency and the FMA together. Several proposals were submitted, received, and negotiated. The same criteria and areas of understanding were used by the FMA as existed in the former plan. In addition, the FMA stated that the premium level in 1972 was adequate and that several other factors were working to promote a more favorable climate in Florida with respect to professional liability claims. Among these factors were:[4]

1) Increased expertise in the defense of claims from the experience developed over almost ten years.
2) Less readiness on the part of plaintiff's attorneys to sue because of past disappointments from vigorous resistance.
3) An increasing awareness on the part of the public of the price of "give-away" court awards.
4) A continuing effort by the FMA to obtain legislative changes which are more favorable. For example. effective July 1, 1972 the statute of limitations applying to professional liability claims was changed from four to two years.
5) Increased awareness on the part of the physician of his exposure to claims and increased interest in prevention.

It is difficult to determine the cause for some of these conditions and whether they exist to any great extent. Certainly, the market situation for coverage in Florida has made many physicians aware of the problems of availability. The public attitude toward awards and the litigation climate can only be measured in terms of future trends in claims made, cases tried in court, and settlement costs.

The three carriers which made the most serious proposals to the FMA were the Argonaut, Chubb and Son, Inc. and Continental National Assurance Company. Of these final candidates, Argonaut was selected as the carrier for the FMA program. The Argonaut proposal granted the FMA all its stipulations, gave the FMA almost complete control over the operation of the program, and agreed to a lower premium level than under the existing plan. Furthermore, the Argonaut's experience and overall stability in the professional liability field was an important determinant.

The arrangement under the new program provides that the FMA form a fully owned stock corporation called FLORMEDCO. Through this corporation the FMA will have control over the entire operation of the program. The London Agency and Harlan, Inc. of Florida in Jacksonville will be the co-brokers and administrative managers of the plan.

Harlan, Inc. was chosen as the selling agency because of its close relationship with independent agents throughout the state, its own force of 23 agencies and affiliates throughout Florida, and its proximity to the FMA in Jacksonville. The FMA feels that with Harlan administering the marketing and sales of the program a broad geographical base with a wide scope of services is provided. One service aspect particularly mentioned is a toll-free telephone line directly to Harlan for any insured or agent to use when a problem arises or information is needed.

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[4] Florida Medical Association, Professional Liability Insurance Program, July 5, 1972, p. 2.

Harlan has already begun to market the plan by mailing introductory announcements of the new plan to all independent agents in Florida through the agency association. In addition, all current members of the FMA will receive notification of the new plan. Those physicians who are already insured through the FMA group plan only have to fill out a short form attached to the introductory letter indicating a desire to be transferred to the new plan and send it to Harlan or their local insurance agent. New applicants are asked to send an enclosed postcard to Harlan for an application form. The physician is asked to submit the completed application to his county medical society. A meeting in Jacksonville was also held with representatives of nearly all the county medical associations to discuss the features and operation of the new plan. Those not in attendance were mailed this information.

The London Agency will perform primarily the same services it rendered under the previous plan. These include keeping all statistical records, handling finances and providing liaison between the company and FMA on claims matters.

Both Harlan and the London Agency are jointly contracted under FLORMEDCO to administer the insurance operations of the plan. The FMA through the corporation will operate the peer review and committee review functions of the program. Thus, the mechanism established by the FMA allows it to remain out of the insurance business yet affords it control over the program.

C. DISTINGUISHING CHARACTERISTICS

The Florida Medical Association has approximately 8,400 members, nearly 1,500 of which conduct their practice for U.S. public health hospitals, veterans hospitals, and educational hospitals, and do not seek professional liability coverage from the FMA. Some 4,400 physicians out of the total eligible participate in the program. St. Paul's underwrites about 1,000 risks and the remaining physicians have coverage with other carriers through their local independent agent. Imperial Insurance Company owned by the Signal Company has recently entered the market in Florida and insured many physicians. These two carriers seek to write selected risks and their sales efforts are directed away from Dade and Broward Counties. The primary reasons for non-participation in the FMA program are lower rates and relationships with local independent agents. A recent rate increase by the St. Paul Company together with the ten percent premium reduction of the new Argonaut program may induce some physicians to switch to the group plan. The rate reduction may also make Argonaut's plan as competitive as other firms.

Argonaut has guaranteed rates in the first year of the plan and also agreed to a five year guaranteed renewable program. All policies under the new plan have a common anniversary date of January 1. All umbrella coverage policies are renewed on July 1.

Both the plan with Employers and the new plan with Argonaut contain the following features:

1. Centralized claims handling.
2. Centralized coordination of legal defense.
3. Peer review at county medical society level providing medical expertise.
4. Self-rating program based on loss experience.
5. Review of eligibility, renewal, and termination of all insured and new applicants by county medical society. Carrier underwriter given final say in all cases (instituted in 1972 by Employers).
6. Complete financial disclosure as to rates, claims and reserves.
7. Active defense of all non-meritorious claims by the FMA.

While these characteristics are essentially the same for both programs, the application of these terms up to this time has not been as successful as the FMA desires. The new program envisions more control by the Association in the operation of the program. Since the prior program with Employers did not yield the expected results, the FMA has taken a more defensive posture with regard to the new plan. It provides for membership and FMA participation at every level and in all matters.

Under the new plan several other services have been established to accomplish this control. The London Agency has been delegated the responsibility of reviewing all established claims reserves and changes in those services. This monitoring will aid the Association in negotiating premiums with Argonaut and will allow evaluation of their loss reserve policy. In addition, independent actuaries at the University of Florida will review all data changes.

The centralized claims service will be handled through one office in Jacksonville where the Argonaut claims adjustors will be notified of any incidents or claims made. An investigation will then be initiated by this office and reserves established depending upon the potential liability or defensibility of the claim. One designated legal counsel will handle every claim and will then delegate cases to other local firms for trial purposes. An independent legal firm will be retained to audit the manner in which legal expenses are being spent. This is an effort to hold rising legal costs to a minimum. For the purpose of reviewing the incidence and causes of malpractice claims, independent medical consultants will be contracted to follow the trends and patterns.

D. RATING FEATURES

The group plan with Employers had six basic classifications into which physicians were classified according to specialty. Five of these classifications are similar to those of most other group programs, following the ISO standard. However, the sixth classification, emergency room physicians, is not found in any other group plan studied. The development of this classification was a direct result of the extensive statistical records kept by the London Agency for the FMA. Over several years of claims experience it was determined that emergency room physicians showed loss experience at the same level as surgeons in class four. Based on these data, Employers agreed to insure these risks separately at the same rate as class four surgeons.

This plan also effected a geographical differential. Two geographical areas are distinguished, Dade and Broward Counties at one rate level in all classifications and the remainder of the state at another level. Because of adverse loss experience due to the high frequency and unusually large size of awards, Dade and Broward Counties are given a higher rate in all classifications. Several companies will not write any professional liability policies in these counties. It is interesting to note the ratios of losses to premiums paid for these jurisdictions. This ratio for Dade and Broward Counties in 1971 was about 92 percent. For the remainder of Florida in that same year, the ratio was 85 percent. Both figures exclude future losses, which may boost these ratios significantly, but in view of the substantial territorial rate differential, their proximity at this time is significant and supports the geographical rating used by Employers.

Under the present basic plan, the limits of coverage a physician may purchase extends from $25,000/75,000 to $100,000/300,000. Partnerships and professional associations may also purchase this coverage; however, a 20 percent surcharge is applied to the basic rates. The Association also sponsors an excess liability program through the Employers' Group which broadens coverage through a package policy to several types of liability. It provides up to $1,000,000 of professional excess liability. Also covered in this excess plan is primary personal liability up to $1,000,000 for personal acts, residences, automobiles, watercraft, and employers' liability. Personal injury liability is covered as well.

There is general agreement among those administering the FMA program that Employers' charged inadequate premiums in the first few years of the plan. Loss experience accumulated and claims payments mounted so that from the period 1963 to 1970, the ratio of losses to premiums paid was 236 percent. Additionally, of the total amount paid in claims, 33 percent went for legal defense costs, with the remaining 67 percent being awarded to claimants. Employers with the approval of the FMA enacted several large premium increases. In retrospect, these increases were insufficient and too late to offset the amount of the total losses. It was also felt by those few carriers vying for the new program that a redundancy estimated between ten and fifteen percent has been built into the current premiums. This overstatement of premium is perhaps an attempt to recover a portion of previous losses. Historically, the group plan provided not only a market for professional liability coverage, but offered this coverage at a level below cost.

The new program with Argonaut preserves the existing classifications under the basic plan and their associated rates as well as the geographical differentials. However, special provisions have been included to insure physicians who have retired and only occasionally practice, who are military consultants, or physicians who are hospital based and who perform charitable work in other community clinics.

Argonaut has agreed to apply a ten percent rate reduction for all classifications due to a redundancy it believes exists in the current premium level. In addition, premiums can be paid on a quarterly basis at no interest charge.[5]

Another change in the new plan stipulates that the minimum basic limits will be $100/300,000. Umbrella coverage will be available from primary limits of $1,000,000 up to a maximum of $5,000,000.

The Association believes that one of the advantages of their group plan is the low expense factor or acquisition cost to Argonaut. Because of the expected large number of participants in the group plan, savings are believed to be made in administration and claims service. The anticipated retention factor for the new group plan is approximately 20 percent. This is composed of commissions and fees to the London Agency and Harlan of three percent each, commissions of five percent to the independent agent placing the policy, a state tax factor of four percent and the remaining five percent going to Argonaut for its own administrative and service costs and potential profit. Of course this does not include income to the carrier derived from investment income on premiums and reserves. Whether this retention factor becomes reality remains to be learned; however, this factor seems to be quite optimistic compared with most other group programs.

Another rating feature written into the new program is the chargeable loss feature. This surcharge mechanism applies to physicians who incur claims losses while covered with Argonaut. If a doctor incurs one claim which results in a payment of loss exceeding $1,000 he will not be surcharged for that claim. However, on the second claim paid incurred over $1,000 for that doctor, his rate will be surcharged 50 percent. The third claim will result in a 300 percent increase in rate, the fourth claim 400 percent, and the fifth claim 500 percent. In lieu of the rate-up, a physician may elect to have a deductible applied to his policy. In this case he would be required to post bond for the amount of the deductible. In theory the surcharge or deductible mechanism for experience rating may be justified. A potential problem area may occur if the doctor believes that he was not negligent even though the carrier settles in excess of $1,000 with the claimant. The philosophy of the FMA with regard to claims defense does provide a partial safeguard. It has been a past policy with the FMA to defend, through litigation if necessary, any claim believed to be non-meritorious. Nevertheless, a grey area does exist with regard to negligence and physicians facing this situation will most probably balk at any rate increase applied because of this. The new plan also provides for premium refunds. At the end of seven years any excess premiums can be used to reduce premium levels or can be given to a charity of the FMA's choice.

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[5] Under a quarterly premium basis, investment of remaining yearly premium by the physician could yield percentage savings in the annual rate.

The Role of the County Medical Society

The medical review of claims and determination of eligibility are the two primary functions of the county medical societies. There are 67 counties in Florida and 42 county medical societies.

In the latter part of 1971, Employers and the FMA agreed to institute professional liability insurance review by county medical societies. This provided that in matters of eligibility, the county society would review a physician's professional standing and decide whether full coverage or restricted coverage should be given. In cases of restriction, it would be determined whether a surcharge or deductible would be applied. Under the new plan, any physician who incurs a claim which amounts to payments in excess of $1,000 will be reviewed by the county society to determine if the physician was negligent and subject to a possible rate-up. Florida also has each year many foreign medical graduates wishing to practice medicine. For these doctors, the county society will review their education to determine if it meets Association standards.

In 1972, the Employers' was forced to undertake a re-underwriting program because of adverse loss experience. A total of 160 physicians was excluded from coverage. In the nine years prior to this only 120 physicians were not allowed to participate in the program. However, assistance was provided for those physicians excluded from coverage and about 50 percent were issued policies in a higher premium surplus market carried by Employers. Several other doctors were excluded because of coverage they had under a hospital policy.

The second primary function of the county society is to review every reported case of malpractice and examine its merit. An important provision in the new plan requires that the physician sign a release that anything arising under his coverage may be discussed by the FMA and that the right to settle any claim lies with the county medical society. In effect the company does not need the written consent of the physician to settle a claim, but must obtain the consent of the county society. This provision may be considered a loss of rights by the physician. However, the doctor can appeal to the state committee on professional matters for a final decision. The state committee will review and audit county society decisions.

A unique situation also occurs in Florida involving the county medical societies. Florida has a Medicare contract with the federal government which has existed for almost three years. This contract authorizes the county societies to maintain a continual profile of all physicians receiving Medicare reimbursements. This computerized profile indicates any physician whose file is not in order; i.e., excessive hospital visits, nursing homes, etc. The county society reviews these selected files and the state audits them. The results are then sent to Blue Shield who then may reimburse the government for excessive payments. A valuable link is established by this process because by reviewing these files the county society is signalled of physicians who may be practicing sub-standardly. These physicians may also present the greatest risk exposure and if insured with the FMA can be monitored.

The Argonaut Insurance Company is also the underwriter of the Florida Hospital Association and insures some 65 hospitals under its plan. This will allow for some carrier savings in the claims investigation and legal defense involving a physician employed under the FMA plan and a hospital in the hospital association if they are named defendants in the same claim. Florida statute states that any two parties can legally agree to mandatory arbitration. The resulting decision from this arbitration is binding on the parties involved. In certain selected communities and selected hospitals, mandatory arbitration may be experimented with. A committee would be appointed by a presiding judge from the community and hospital to arbitrate the case. In addition, an arbitration panel may be established to determine whether a claim should be charged to a particular doctor/defendant or hospital/defendant if Argonaut insures them both. Both of these mechanisms do not currently exist but may be attempted in a few selected areas for study.

Claims Prevention Efforts

The county medical societies play a key role in the claims prevention aspects of the program. After all claims are reviewed and the method of settlement has been determined, a written account of the case is written with the physician's identity remaining confidential. These case studies of actual experience are then distributed to all county societies for review. The staff and members of the county society are advised as to the patterns and trends of these cases. Furthermore, the findings and recommendations of outside medical specialists as to Florida professional liability experience is also made known to the county societies. Argonaut provides one full-time employee to work solely on claims prevention matters analyzing trends and developing educational materials. An added factor is that the London Agency keeps statistical abstracts on all claims. Frequently, administration members of the FMA working with the professional liability program give lectures at county medical society meetings on the causes of incidents and methods doctors should use to reduce exposure to incidents. Typically, the causes of malpractice follow the pattern of most other states; i.e., poor doctor-patient relationship, inadequate record keeping, inadequate use of informed consent, etc.

The FMA experience has shown that a substantial number of reported claims are non-meritorious or nuisance claims. It has been the Association's position to defend any claim of this nature. Over the period of their group program, 286 suits have gone to trial which the FMA decided were non-meritorious and wished to defend. Of these cases, only four were lost through litigation. The FMA believes this defense policy has discouraged many plaintiff's attorneys from taking action on non-meritorious claims.

TABLE A-2

THE EMPLOYERS' FIRE INSURANCE COMPANY
ANNUAL PREMIUM RATES FOR FLORIDA PHYSICIANS AND SURGEONS

CLASSIFICATIONS	$100/$300,000*	
	DADE & BROWARD	REMAINDER OF STATE
I. BASIC CHARGES:		
1. Physicians–no surgery	$ 682	$ 383
2. Physicians–minor surgery or assiting in major surgery on own patients.	1187	670
3. Surgeons–general practitioners who perform major surgery or assist in major surgery on other than their own patients, and cardiologists (including catheterization but not cardiac surgery), ophthalmologists and protologists.	2570	1452
4. Surgeons–cardiac surgeons, otolaryngologists (no plastic surgery), general surgeons, urologists and vascular surgeons.	3425	1935
5. Surgeons–Anesthesiologists, neurosurgeons, obstetricians-gynecologists, orthopedists, otolaryngologists (including plastic surgery) and plastic surgeons.	4283	2415
6. Emergency Room Physicians.	3425	1935
II. ADDITIONAL CHARGES:		
7. Employed Physician as defined in 1. above.	167	96
8. Employed Physician as defined in 2. above.	296	167
9. Employed Surgeon as defined in 3. above.	646	359
10. Employed Surgeon as defined in 4. above.	862	484
11. Employed Surgeon as defined in 5. above.	1074	605
12. Employed Technician-Laboratory, Radium or Pathological	18	18
13. Employed Assistants	84	48
14. X-Ray Therapy		
a. by Insured Physician	682	383
b. by Insured Surgeon	862	484
c. by Employed Physician	167	96
d. by Employed Surgeon	212	121
e. by Employed Technician	54	51
15. Shock Therapy		
a. by Insured Physician	682	383
b. by Insured Surgeon	862	484
c. by Employed Physician	167	96
d. by Employed Surgeon	212	121

PARTNERSHIPS and/or PROFESSIONAL ASSOCIATIONS: (2 or more members) Add 20% to total basic charge.

*SPECIAL NOTE: Rates under Argonaut program will be reduced by 10%.

Table A-3. FLORIDA MEDICAL ASSOCIATION: PAYMENTS TO CLAIMANTS ON CLOSED CLAIMS, THROUGH MAY, 1972*

By Year Closed	Total Average Per Claim
1963	–
1964	$7,655
1965	3,996
1966	4,190
1967	1,265
1968	2,556
1969	2,725
1970	2,049
1971	6,230
1972	6,653
Total	$3,465 (average)

Table A-4. NUMBER OF INSURED PHYSICIANS

Year	# of Insured Physicians
1963	390
1964	655
1965	738
1966	1,250[a]
1967	1,620
1968	2,297
1969	3,093[b]
1970	4,086
1971	4,639
1972	4,000[c]

*Statistics from the London Agency, administrator for Florida Medical Association's Professional Liability Insurance Program.

[a] Provision allowed that any independent agent could place coverage with FMA plan.

[b] Increase primarily due to Medical Protective leaving Florida market in 1968.

[c] Undetermined for year; however, could show a decrease due to market opening up because of increased rates in FMA plan.

Minnesota Medical Association

A. DEVELOPMENT AND IMPLEMENTATION

A group professional liability insurance plan was first started by the Aetna Fire and Casualty Company in Minnesota. This plan was only endorsed by the Minnesota Medical Association, and the Association played a very minor role in the program. In the early to mid 1950's, as many as 23 companies were in the Minnesota professional liability insurance market with no carrier possessing a significant share of the market. St. Paul Fire and Marine Medical Protective, and Aetna were the largest carriers. The number of Minnesota physicians associated with any one carrier was relatively small, and a competitive but unstable situation existed. The situation was characterized by large incremental rate increases. Premium hikes of 50 and 100 percent were not uncommon. Compared to other states and counties, Minnesota had one of the highest average rate levels in the nation. The Association felt that the malpractice problem was not sufficiently critical to warrant the rates.

The Association believed that no carriers had a share of the market sufficient for establishing premiums or covering moderately heavy losses. Also carriers were sometimes quick to cancel a physician who had a small claims loss. Physicians were almost forced into buying fire, automobile, and other liability coverages in order to secure professional liability protection from a carrier. In addition, carriers entered and left the market continually.

The Association's insurance committee discussed forming a group plan with the insurance commissioner of Minnesota, underwriters of several major carriers and a large insurance broker, Marsh and McClennan. Few major carriers were interested in establishing a group plan, but St. Paul decided to undertake the risk. The St. Paul Company fit the requirements of the Association by having financial stability plus expertise in the professional liability field.

St. Paul is an agency company and the Association was required not to retain a broker nor could independent agents sell the plan. Agents contracted to do business with St. Paul were the sole selling force. There were two immediate results of this. First, the selling costs were higher since the agent's commission is greater than the fee a broker would charge for doing the sales on a volume basis. Second, initial participation was hampered by physicians wishing to do business with their local agents. Nevertheless, the availability of coverage at lower rates eventually enticed the majority of physicians. Initially in 1956, 750 physicians joined the plan. Now the group program enjoys a participation rate in excess of 90 percent or about 3,100 insured physicians.

B. CHARACTERISTICS

The policy is a comprehensive liability protection program. Covered in the policy is professional liability, office premises and personal injury liability, offices premises medical payments, and defendants' reimbursement coverage. The professional liability coverage applies to all but a small portion of the annual rate.

The plan is self-rating in concept with the company basing rates upon group experience. Limits of liability extend from $25/75,000 to $100/300,000, and excess coverage is available for a million dollars or more.

An extremely important aspect of the program is the peer review committee which provides for physician participation and review of medical matters by physician peers. The services of this committee extend to claims review, eligibility recommendations, and participation in claims prevention aspects.

The carrier offers centralized claims service through two service centers, specialized defense attorneys, and close communication and participation with the peer review function and the Association's insurance committee.

C. RATES

There are five classifications under which a physician may be rated depending upon his particular field of practice. St. Paul originally had only two classifications, general physicians and surgeons, but they expanded to four and then five as ISO did. There is no geographical rate differential within Minnesota. Claims records are kept by specialty, but St. Paul does not feel enough experience has developed to set rates by specialty.

Most individual carriers used the rating bureau's advisory rates for Minnesota. St. Paul, after underwriting the group plan, reduced rates below the ISO levels. Seven additional rate decreases followed putting Minnesota in the bottom quarter of average rates for states in the nation. The pattern was reversed in recent years. There have been rate increases of 29, 30, and 82 percent in the last three years reflecting the increased number of claims and size of claims payments. Increases result from changes in the basic rate and changes in the expansion factors used to determine rates for higher limits. Yet the rates charged by St. Paul are still only half the rates advised by ISO.

D. CLAIMS HANDLING

St. Paul has two claims service centers within the state to service the plan's insureds. Within these centers are claims departments with adjustors who investigate all reported incidents and claims. These adjustors are full-time professionals who work solely on professional liability cases. This specialization is one of the benefits derived from the volume of premiums from the group and is necessary due to the number of physicians insured and frequency of claims incurred. Underwriters at the service centers review loss experience, establish reserves, and determine eligibility and coverage requirements.

A claims staff is also supported at the home office in St. Paul, Minnesota. This central office receives notice on all claims reported over $7,500 and advice is given to the service center on how to proceed in establishing reserves. A copy of all reserves set up in the home office is sent to the service center and the Association. Generally, all daily reports are handled at the service center while the home office establishes rates and large reserves.

When it is necessary to defend a case, independent attorneys are retained to handle the defense. These legal firms are obtained for their experience and expertise in the professional liability field.

An additional feature in the policy is the payment of any expenses or loss of time incurred by the physician in attending trial.

E. PEER REVIEW

The peer review committee for the Association came into effect with the group plan and serves any physician who is a member of the Association, even if not insured in the group plan.

There are about 20 members of the committee representing the major specialties. The primary activity of the committee is the review of claims against physicians. Peer review action may be initiated by the carrier, the physician, or the defending attorney. The committee will assign a specialist in the field of the defendant doctor to analyze the claims file and to submit recommendations to the committee for defense action. In many cases the doctor is allowed to participate as the committee explores further action.

There is agreement between the carrier and the Association that any claim filed which is deemed without merit by the peer review committee and the carrier will be defended regardless of the cost. This philosophy arose from the pregroup plan situation when most carriers chose to settle a claim without merit rather than defend it in court. The expected long-term effect of this policy is to discourage plaintiff attorneys from accepting nonmeritorious claims and thereby reduce the number of "nuisance" claims. The Association believes the approach is having the desired effect.

Another important responsibility of the peer review committee is retrospective review of physician eligibility in the program. Virtually every new physician is given a chance to participate. When a physician is refused renewal for any reason, he can appeal to the committee for a review. If loss experience for the physician is high, the committee may recommend that the carrier only offer coverage at the basic limits at standard rates and let the physician seek excess coverage with another firm. Nevertheless, in any underwriting matter, the carrier has the final decision and no substandard rating is offered.

Finally, since the committee receives a summary report on all claims which are open or have been settled and paid, they are best able to identify the problems and communicate them to the membership.

Although county medical societies exist in Minnesota, they do not participate in the peer review function as in some other state group plans. Recently, a study was undertaken to determine whether it was feasible to conduct peer review on a local basis. Fifty hospitals and fifty nurses were selected to participate in the review of 20 common diagnoses. Forms and questionnaires were developed and sent, one part to medical librarians to be completed from hospital records, and one part to physicians for their review. The results showed that expert review of medical cases did not occur. Local biases and the "conspiracy of silence" (physicians unwilling to testify against other physicians) were found to persist. These results indicate that peer review is not conducive at the county or local levels in Minnesota. The Association believes that centralized peer review is more conducive to effective review control.

Table A-5. MINNESOTA PROFESSIONAL LIABILITY PROGRAM
SCHEDULE OF RATES, JUNE 15, 1972

	$100/300,000 limits St. Paul	$100/300,000 limits ISO
Class I. No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	$209	$404
Class II. Minor surgery or obstetrical procedures not constituting major surgery	$368	$706
Class III. General practitioner performing or assisting in major surgery on other than their own patients, including Cardiologists who engage in catheterization but do not perform cardiac surgery. Ophthalmologists. Proctologists	$794	$1,531
Class IV. Specialists. Cardiac Surgeons. Otolaryngologists—no plastic surgery. Surgeons—General (Specialists in general surgery). Thoracic Surgeons. Urologists. Vascular Surgeons	$1,058	$2,041
Class V. Specialists. Anesthesiologists. Neurosurgeons. Obstetricians-Gynecologists. Orthopedists. Otolaryngologists-Plastic Surgery. Plastic Surgeons	$1,323	$2,552

Medical Society of State of New York

A. DEVELOPMENT AND IMPLEMENTATION

The New York State Medical Society has sponsored a group insurance plan for medical liability since 1921. From the plan's inception, it was managed by an indemnity representative appointed by the Society, Colonel H. F. Wanvig. As the broker, Wanvig, together with the Society, established a program and set out to find a carrier who would accept their terms and underwrite the malpractice plan. In selecting the carrier, the State Society wished to assure its members prompt, experienced claims service, availability of insurance to all members deemed eligible by the Society, and protection of the professional and financial interests of its members. It is important to note that the initiative for stating the terms and securing the plan came from the State Society through its broker.

The Aetna Casualty Company was the original carrier of this plan and was succeeded by the Yorkshire Indemnity Company. Heavy settlements and claims payments combined with insufficient assets forced Yorkshire to drop the New York plan in 1949 and forego the malpractice business altogether. The Yorkshire Indemnity Company has paid out much more in claims than it ever collected in premiums and is still experiencing claims. Employers' Mutual of Wausau, at that time a novice in the professional liability field, became the third underwriter of the plan and remains the carrier today.

Wanvig, Inc. is licensed to sell individual insurance policies in New York State and has acted as both the broker and agent for the plan. Under arrangements with the Society and the carrier, premiums are paid to Wanvig, Inc., deposited to a special account, and net premiums remitted monthly to the insurance carrier. Wanvig, under this agreement is restricted to the handling of professional liability and related insurance for members of the Medical Society of the State of New York.

In addition to acting as broker and agent, the indemnity representative serves as program adviser to the Society and its individual members. Numerous inquiries concerning malpractice insurance matters are handled daily, and developments within the insurance field are followed with information and recommendations being made available to all Society members. Since 1921, the records of insured members have been kept at the broker's office. Suits, claims, and incidents are reported to this office and then sent to Employers' claims representatives. Records relating to their status and costs are also maintained by the broker.

The New York Medical Society also employs an actuary, currently from Peat, Marwick, and Mitchell, who reviews all the broker's records and stays abreast of the company's rates and rate-making practices.

B. CHARACTERISTICS

There are approximately 27,000 physicians who are members of the New York State Medical Society of which some 21,000 are insured under the group program. An important benefit offered by this program is the availability of coverage to any member of the Society who is deemed eligible for coverage by the Society's Professional Medical Liability Insurance and Defense Board. Therefore, the Society, not the insurance carrier, has jurisdiction to determine who will be covered by the plan. This protection also extends to the matter of cancellation. As long as the program continues, a member's policy cannot be cancelled except for nonpayment of premium unless the Board agrees that such action is justified. This provision places the determination of insurability not at the discretion of the carrier, but in the control of the Society.

The program affords coverage for physicians and surgeons including legal defense and indemnity to the stated limits for claims and lawsuits alleging injury or death resulting from medical malfeasance. This protection extends to the insured's liability for employed nurses or technicians, for other physicians acting as partners, or to physicians temporarily substituting in his absence.

Legal defense is given to any insured member of the plan when he needs it for claims allegations. State Society and county medical society committees and panels convene to render expert advice on claims matters. The defendant doctor or the Society can initiate these proceedings.

The program has also developed methods of identifying and examing those medical procedures usually involved in malpractice exposures. With this information practical suggestions are passed on to the physicians in the form of written case studies. Another facet to this claims prevention activity is educational booklets, magazine articles, publicity releases, and advertisements dealing with malpractice-related problems. These materials originate from and are distributed by the Society, broker, or carrier. While these materials facilitate the flow of information to the physician, there is no assurance he will read it. The limitations of this method are evident and new approaches should be investigated.

C. RATES

There are seven classifications of rates into which physicians are assigned according to specialty. Although these specialty classifications are uniform across the State of New York, the rates within each classification vary according to geographical area.

There are four such geographical areas: Metropolitan Area (five counties of New York City and Nassau County); Suburban Area I (Orange, Ulster, and Westchester Counties); Suburban Area II (Rockland, Suffolk and Sullivan Counties); and Upstate Area (all remaining counties). Metropolitan Area and Suburban Area II have identical rates for 1972 because the loss experience for each area is approximately the same. Suburban Area I has lower rates for each classification than the Metropolitan Area and the Suburban Area II with Upstate Area having the lowest set of rates of all New York areas.

Often the opinion is expressed that Upstate physicians are paying for the losses of New York City physicians. Actually, the relationship between rates and losses for each territorial area is remarkably accurate. Cumulatively, from 1958 to 1971, the Upstate territory paid 20% of the total premiums collected and has incurred 22% of the total paid and pending losses; whereas, the Metropolitan Area paid 65%, having incurred 67% of the losses.

The maximum limits on coverage for each classification within any area is $200/600,000 with the majority of doctors choosing the $500/1,500,000 amounts. In the New York program, rates have increased 439% in the last five years. While the State Society verified the need for these increases through actuarial review, it is extremely concerned that a lid be put on rates. Employers' is currently developing a system to adjust rates among classifications and territories according to developing trends rather than push the entire rate structure higher.

Statistics developed through 1971 show that State-wide, more cases were closed in 1971 and 1970, and they cost less money (1970 average per case, $13,272; 1971 average per case $10,112). However, during 1971 more new cases were set up than in 1970 (1,648 compared to 1,409). Furthermore, more old claims became suits during 1971 (564 suits started in 1970, 803 in 1971). The backlog of suits grew from 2,203 in 1970 to 2,549 in 1971. In addition, the insurance carrier felt that many of the older cases still pending had been under-reserved.

It is probable from this set of statistics that the future will not yield lower losses or rates. In the past, it has been customary for some physicians within a specialty group to switch to a different carrier because of a rate increase. The Society has continually stressed to these splinter groups the advantages of uniting in the common defense of a malpractice case. Premiums and losses are tabulated in the New York program by specialty; therefore physicians within a specialty are paying premiums for losses within that specialty. In addition, the Society cautions these individuals that nationwide specialty group insurance plans have fared poorly. The American College of Obstetricians and Gynecologists does not even offer its group plan to its New York State members.

One particular point of pride for the New York State plan is that their expense factor (the Company's cost of doing business) is only 15.5 percent. The expense factor consists of the marketing, selling, and administration of the plan including taxes, loss adjustment, and the broker's fee. The large number of insured physicians in the New York plan is one probable reason for the low expense factor. The high rate of participation has allowed Employers' to keep advertising and promotion costs at a minimum. Having one indemnity representative acting as both broker and agent also contributes to expense savings. The high premium volume presumably allows a lower broker's fee. A lower expense factor has at least two advantages for the Society. First, it allows a greater percentage of the premium to be allocated toward loss and settlements payments; or it could, in the event of good loss experience, lower the premium. Second, it allows the insurance carrier discretion to utilize some premium income for claims prevention activities. The extent to which either of these benefits accrue to the New York plan is not clear.

D. SELF-REGULATORY PROVISIONS

The Professional Medical Liability Insurance and Defense Board was created in 1946 as a special committee of the House of Delegates. The by-laws of the Society state that the Board will study and supervise for the Society all matters dealing with malpractice insurance. Seven members, all practicing physicians, are appointed to five-year terms by the president of the Society. The secretary, treasurer, legal counsel, and broker are ex-officio members with voice, but without vote. The Board, which meets once a month, has recently experienced increased workload and there is pending proposal to increase the number of Board members from seven to nine. In addition, the Board recently set up three subcommittees in specialty areas to investigate the causes of specialty malpractice costs.

The responsibilities of the Board are:

1. Review the malpractice group programs as a whole for New York State.
2. Make recommendations based on this review to the Council of the Society which then passes them on to the Society's House of Delegates.
3. Determine the eligibility of physician members for the group insurance program. Make recommendations concerning high risks on whether to continue or modify a policy. Policy modification usually means higher rates.
4. Oversee application of entire program to all physician members.

The responsibility to decide eligibility for its members in the insurance program is the Board's most important mandate. However, it is *not* within the jurisdiction of this Board to hear or make recommendations on the defensibility of malpractice cases. This duty is primarily a county medical society responsibility.

In determining the eligibility of a physician for participation in the group program, the process typically begins after a doctor's application for insurance is sent to the broker's office. If the doctor has no loss record and he is a member in good standing of the Society, then he is placed in the appropriate classification and insured. If any question exists concerning the physician's eligibility, the carrier's underwriter will examine the application. At this point, the application may be approved at a standard rating, rated up, restricted in coverage or practice, or the company may request that the Board hear the case and render a decision. In all cases, the physician has the recourse of appeal to the Board for a decision. The decision of the Board is final and the carrier must uphold it. In no case can a doctor's coverage be dropped (except for nonpayment of premium) without the Board's consent.

In recent years the increasing number of physicians involved in multiple malpractice action has forced the Board to direct the discontinuance of certain individual policies. During 1970, the Board heard 96 cases concerning eligibility for renewal and rejected nine physicians. In 1971, 105 cases were heard and again nine were turned down. A total of 167 cases were rated up in 1971 by the insurance company. The existence and powers of the Board in determining eligibility matters on insurance is the strongest selling point of the group program as it insures a continuing availability of coverage for eligible members.

It must be said that the Society has achieved several objectives as sponsor of the group professional liability program. However, there are numerous areas of the malpractice problem which the Society itself cannot control. It has recognized certain aspects in the occurrence and handling of malpractice cases and has been powerless to change them.

The Society has been especially concerned with the long time lag between the time of an act of alleged malpractice and the time the suit is concluded. One of its objectives has been to introduce legislative changes to shorten this lag. The statute of limitations in New York State has gradually expanded over the years. The Society would like to see this trend reversed. In the case of children, the Society has recommended that the law be changed so that the statute will commence when the minor becomes eighteen years of age, the new voting age. In the realm of foreign objects, the Society would like the statute which now runs from the time of discovery tightened. Also in terms of the litigation process, the Society hopes to introduce bills to expand the amount of court costs that will be collectible by the successful defendant to include the costs of transportation and perhaps even attorney's fees. Another snag in the legal process occurs when cases are not put "on file" (scheduled for court) and therefore are not moved along court calendars. This severely slows down the processing of cases and inflates the eventual litigation costs. The Society has mentioned this problem several times in the *New York State Journal of Medicine*, specifically in the Journal of January 1, 1972, and it has recommended that the service of a summons be deemed improper unless the case has been put "on file."

The Society also has been active in developing objectives for physician education. In the *New York State Journal of Medicine*, January 1, 1970, in a report by the Board to the Council of the State Medical Society, the following five steps of an education program it hoped to implement were outlined.

1. Require that all new applicants to the State Society Malpractice Insurance Program attend a seminar on malpractice problems given under the auspices of the Malpractice Insurance and Defense Board, such as the program on driver education for automobile insurance.
2. Offer by letter to all medical schools in the State a series of lectures or a panel program as a required portion of the curriculum of the junior or senior-level student, under State Society sponsorship.
3. Establish a speakers' bureau of attorneys, physicians, and insurance representatives to be available to all segments of the medical community within the State. These panelists would attend community hospital programs, medical society meetings, and others. All publicity of the availability of such a bureau would be disseminated by State Society news releases, publications, and *Journal*, soliciting invitations in an effort to keep the medical communities knowledgeable of malpractice problems on a continuing basis.
4. Allocate time each year for a seminar on malpractice as a part of the scientific program at the annual meeting of the State Medical Society.
5. Establish malpractice workshops on an annual basis in conjunction with the annual meeting. All members of the County Professional Liability Review Committees would be invited to attend, to exchange information, and to become better informed.

E. COUNTY MEDICAL SOCIETIES

The most important function of the county medical societies in New York State is the peer review process rendered by the malpractice defense committee. This malpractice defense committee typically has a minimum of six and maximum of 24 members representing most specialties and hospitals within its jurisdiction. The committee meets monthly and analyzes suits and pending malpractice claims. Cases reach the committee's attention through the physician's attorney who is assigned by the Society, when additional advice is needed. What is usually sought is a recommendation on whether the case is meritorious or not. When a case is brought before the committee, a specialist in the same field as that of the defendant doctor is asked to review the case and present his findings to the committee. The defendant doctor, the defendant's attorney, the carrier's representative, and the full committee are usually in attendance. After hearing arguments concerning the merits of the case, the following outcomes usually result:

1. The physician deviated from acceptable practice.
2. The specialist reviewing the case will be asked to testify that the physician was not negligent.
3. The case should be settled because the physician is vulnerable in some areas.

The findings and recommendations of this committee are not binding upon the defendant, and his attorney may decide to ignore the results. Also, no written minutes are recorded of the hearings to keep the testimony of the medical experts confidential and to protect the doctor's reputation. Equally significant is the fact that no final action may be taken by the insurance carrier in a malpractice case without the written consent of the doctor.

There exists one further mechanism if the doctor refuses to settle and the carrier has independent experts that say the suit cannot be defended. If this circumstance occurs then the doctor has the right to bring his case before a Medical Arbitration Panel of specialists. The doctor, the insurance company, and the State Society each select a specialist to sit and hear the case. After thorough review, their decision is legally binding on both the doctor and the carrier.

In all actions before the County Medical Society Malpractice Defense Committee and the Medical Arbitration Panel, the claimant who has initiated action against the doctor is not involved in the proceedings. These hearings are strictly for the benefit of the doctor and the insurance company to assist them in determining a proper course of action based on expert testimony concerning the merits of the case.

Currently, in Suffolk County, New York, the County Bar Association and County Medical Society have cooperated in establishing an arbitration panel in which medical and legal experts convene to judge the merits of a case. The results of their inquiry is *not* binding upon the parties involved. It is too early to comment on the results of this experiment, but a similar body has operated in New Jersey with the recommendation of the panel binding on the parties up to a certain limit.

An important by-product of the County Medical Society proceedings is that because all hospitals and specialties are represented, the physicians on the Committee will return to meetings with hospital staff or specialty groups and without mentioning specific defendants will discuss what they learned from the cases. In this way, practices which could be avoided and the means of preventing malpractice occurrences are presented and many times implemented. Thus, claims prevention is a possible benefit of committee hearings.

Several other aspects of the group program are satisfied by an active County Medical Society. Every two or three years the County Society will offer its members an education program concerning trends in incidents and claims. Recently, when these programs were being held by the counties, members of the State Society performed a skit simulating a doctor being interviewed before a malpractice committee. A great deal of education can be imparted within the county framework for new doctors and medical personnel on all aspects of the malpractice problem.

Additionally, the County Society has the important task of informing the State Society Board of any circumstances or facts regarding a physician's eligibility for admittance into the group program.

F. LOSS PREVENTION

The New York State Medical Society has a public relations committee which keeps abreast of claims trends and notifies member physicians of changes in these trends. Because the Society has access to claims records and experience frequency from its broker, it is able to inform members of a specialty about medical problems particular to that specialty.

The insurance carrier, Employers' Insurance of Wausau, also contributes in malpractice prevention efforts. The company has a person specifically engaged in incident prevention. This person works with the claims department doing analytical research on reported areas of incidents. Company representatives are also invited to speak to certain groups at both the State and county levels.

The broker also engages in the effort by notifying the carrier of trend changes and publishing articles and case studies for group members.

Medical Society of Virginia

A. DEVELOPMENT AND IMPLEMENTATION

The Medical Society of Virginia began a group professional liability insurance program in 1956 with the St. Paul Insurance Company. In the early 1950's, the cost of medical malpractice coverage had risen dramatically as a result of several large settlements. The available market for physicians consisted of numerous carriers with a piece of the market, but no carrier holding a significant share. The Aetna Casualty Company along with St. Paul were two of the major carriers writing policies in Virginia. Faced with larger losses and an inadequate premium base, the Aetna decided that a physician must carry all his liability insurance with them to be eligible for professional liability coverage.

The insurance committee of the Medical Society decided that a group plan was needed to stabilize the market, to facilitate availability and hopefully to halt the rise in rates. Several competitive bids were invited from major casualty companies. The year before, St. Paul had begun writing a group plan for Minnesota physicians with an initial reduction in rate. This plus St. Paul's financial base and experience in the professional liability field were the factors which persuaded the society.

St. Paul is an agency company and the plan is marketed through their licensed agents. Advertisements in the Society's newsletter request interested physicians to contact their local St. Paul agent. Ninety-seven percent of the Society's 4300 members participate in the plan. Aetna still insures a few Virginia physicians, and recently a few carriers have reentered the market.

B. CHARACTERISTICS

The Medical Society of Virginia incorporates most of the features commonly found in group plans; however, society involvement is minimal with the carrier both operating and administering the plan. The basic features are:

- Self-rating program based on Virginia physicians' experience.
- Specialized claims handling and defense.
- Insurance Committee annual review of program with carrier and body of appeals.
- Medico/legal panel review of some claims.

C. RATES

Before the Society instituted a group program, individual carriers in Virginia used the ISO advisory rates. After the group plan came into effect, St. Paul reduced the rates during the early years. In 1970, the trend reversed with an average increase of 28 percent and in 1972 rates again increased an average of 34 percent. However as seen in TableA-8 the overall rate structure of St. Paul for Virginia is about 18 percent below ISO standard rates.

The rating structure is based on the five standard ISO classifications. Rates are assigned to each classification and experience data is collected on that basis. The acquisition cost of the plan for the carrier (retention factor) has steadily been reduced over the life of the program. Originally more than half the premium dollars collected were used by the company for administering the program. By 1961 and through 1963, the allocation of premiums was 49 percent for administration, acquisition, and production costs and 51 percent for losses. Nine years has changed this ratio substantially with 70 percent being available for loss payments and reserves.

D. CLAIMS HANDLING AND DEFENSE

The regional office of St. Paul for the Virginia plan is in McLean, Virginia. This office's underwriters and claims adjustors service the physicians on a daily basis. There are field offices located in Roanoke and Richmond which have claims investigators working on professional liability cases along with other casualty lines. At the regional office, the claims specialists deal strictly with malpractice cases. This office reviews all claims, sets up reserves, and can settle cases up to $5,000. Cases in excess of this amount are usually sent to the home office in Minnesota for review. The regional office reviews all claims arising from the group plan and will reexamine any open files every six months. In addition, this office keeps all claims data and physician insurance records. The responsibility for establishing rates and setting rate making policy rests with the home office.

The number of claims being filed against physicians has risen recently to nearly 150 cases a year. The company finds that a large portion of these claims originate in urban areas. The company reserves the right to make any decisions concerning claims defense and will assign cases to legal firms which specialize in professional liability cases. The company and Society agree that any claim determined to be without merit will be defended. It is felt that this policy will discourage plaintiff attorneys from accepting "nuisance" claims. The effect of this policy has been high legal costs which constitute a significant share of claims expense.

Table A-6

RATES FOR DOCTORS WITH ACCEPTABLE LOSS EXPERIENCE

Effective for Policies Dating on and after July 1, 1972

Limit No. 1, EACH PERSON AGGREGATE, is the total limit of liability for all damages because of injury to which this insurance applies, sustained by any one person and Limit No. 2, GENERAL AGGREGATE, is the total limit of the company's liability for all damages occurring in the effective policy period, subject to the provision respecting "each person aggregate."

METROPOLITAN AREA

(The five counties of New York City and Nassau County)

LIMIT NO. 1	LIMIT NO. 2	CLASS 1A	CLASS 1	CLASS 2	CLASS 3	CLASS 4	CLASS 5	CLASS 6	CLASS 7
$ 25,000/	75,000	$4,860	$3,200	$1,952	$1,406	$ 898	$ 702	$546	$273
50,000/	150,000	5,494	3,618	2,207	1,589	1,016	793	618	309
100,000/	300,000	6,081	4,004	2,442	1,759	1,124	878	684	342
200,000/	600,000	6,551	4,313	2,631	1,894	1,211	946	737	368
300,000/	900,000	6,833	4,499	2,744	1,976	1,263	986	768	384
500,000/	1,500,000	7,138	4,700	2,867	2,064	1,319	1,031	803	401
1,000,000/	3,000,000	7,889	5,195	3,168	2,281	1,458	1,139	887	444
2,000,000/	6,000,000	8,805	5,798	3,536	2,546	1,628	1,271	990	495

Rates for other limits will be quoted upon request

Check in payment of premium may be made payable to H.F. Wanvig, Inc. 2 Park Ave., New York, N.Y. 10016

Additional premiums required if the following procedures are to be covered. A special application form is required and will be furnished upon request.

LIMIT NO. 1	LIMIT NO. 2	SUPERFICIAL X-RAY THERAPY	DEEP AND SUPERFICIAL X-RAY THERAPY AND/OR ISOTOPE TELETHERAPY	ELECTROSHOCK THERAPY
$ 25,000/	75,000	$155	$331	$126
50,000/	150,000	176	374	143
100,000/	300,000	194	414	158
200,000/	600,000	209	446	170
300,000/	900,000	218	466	178
500,000/	1,500,000	228	486	185
1,000,000/	3,000,000	252	538	205
2,000,000/	6,000,000	281	600	229

Rates for physicians employed exclusively by the Federal Government (no outside medical practice) are 25% less than those quoted above.

Rates for physicians in active military service will be quoted upon request.

RATES FOR DOCTORS WITH ACCEPTABLE LOSS EXPERIENCE

Effective for policies Dating on and after July 1, 1972

Limit No. 1, EACH PERSON AGGREGATE, is the total limit of liability for all damages because of injury to which this insurance applies, sustained by any one person and Limit No. 2, GENERAL AGGREGATE, is the total limit of the company's liability for all damages occurring in the effective policy period, subject to the provision respecting "each person aggregate."

UPSTATE AREA

(All Counties except New York City, Nassau, Orange, Rockland, Suffolk, Sullivan, Ulster and Westchester)

LIMIT NO. 1 / LIMIT NO. 2	CLASS 1A	CLASS 1	CLASS 2	CLASS 3	CLASS 4	CLASS 5	CLASS 6	CLASS 7
$ 25,000/ 75,000	$2,283	$1,441	$ 878	$ 633	$404	$306	$246	$122
50,000/ 150,000	2,581	1,629	992	716	456	346	278	138
100,000/ 300,000	2,857	1,803	1,098	793	505	383	308	153
200,000/ 600,000	3,077	1,942	1,183	854	544	413	332	165
300,000/ 900,000	3,210	2,025	1.234	890	567	431	346	172
500,000/1,500,000	3,353	2,116	1,289	930	593	450	362	179
1,000,000/3,000,000	3,706	2,339	1,425	1,028	655	497	400	198
2,000,000/6,000,000	3,353	2,610	1,590	1,148	731	555	446	179

Rates for other limits will be quoted upon request

Check in payment of premium may be made payable to H.F. Wanvig, In.c, 2 Park Ave., New York, N.Y. 10016

Additional premiums required if the following procedures are to be covered. A special application form is required and will be furnished upon request.

LIMIT NO. 1 / LIMIT NO. 2	SUPERFICIAL X-RAY THERAPY	DEEP AND SUPERFICIAL X-RAY THERAPY AND/OR ISOTOPE TELETHERAPY	ELECTROSHOCK THERAPY
$ 25,000/ 75,000	$155	$331	$126
50,000/ 150,000	176	374	143
100,000/ 300,000	194	414	158
200,000/ 600,000	209	446	170
300,000/ 900,000	218	466	178
500,000/1,500,000	228	486	185
1,000,000/3,000,000	252	538	205
2,000,000/6,000,000	281	600	229

Rates for physicians employed exclusively by the Federal Government (no outside medical practice) are 25% less than those quoted above.

Rates for physicians in active military service will be quoted upon request.

RATES FOR DOCTORS WITH ACCEPTABLE LOSS EXPERIENCE

Effective for Policies Dating on and after July 1, 1972

Limit No. 1, EACH PERSON AGGREGATE, is the total limit of liability for all damages because of injury to which this insurance applies, sustained by any one person and Limit No. 2, GENERAL AGGREGATE, is the total limit of the company's liability for all damages occurring in the effective policy period, subject to the provision respecting "each person aggregate."

SUBURBAN AREA I

(Orange, Ulster and Westchester Counties)

LIMIT NO. 1 LIMIT NO. 2	SUPERFICIAL X-RAY THERAPY	DEEP AND SUPERFICIAL X-RAY THERAPY AND/OR ISOTOPE TELETHERAPY	ELECTROSHOCK THERAPY
$ 25,000/ 75,000	$155	$331	$126
50,000/ 150,000	176	374	143
100,000/ 300,000	194	414	158
200,000/ 600,000	209	446	170
300,000/ 900,000	218	466	178
500,000/1,500,000	228	486	185
1,000,000/3,000,000	252	538	205
2,000,000/6,000,000	281	600	229

Rates for other limits will be quoted upon request

Check in payment of premium may be made payable to H.F. Wanvig, Inc., 2 Park Ave., New York, N.Y. 10016

Additional premiums required if the following procedures are to be covered. A special application form is required and will be furnished upon request.

LIMIT NO. 1 LIMIT NO. 2	CLASS 1A	CLASS 1	CLASS 2	CLASS 3	CLASS 4	CLASS 5	CLASS 6	CLASS 7
$ 25,000/ 75,000	$3,805	$2,401	$1,463	$1,054	$ 673	$499	$410	$205
50,000/ 150,000	4,301	2,714	1,654	1,191	761	564	463	232
100,000/ 300,000	4,760	3,004	1,831	1,318	842	624	513	256
200,000/ 600,000	5,128	3,236	1,973	1,420	907	672	552	276
300,000/ 900,000	5,349	3,376	2,057	1,481	946	701	576	288
500,000/1,500,000	5,588	3,526	2,149	1,547	988	733	602	301
1,000,000/3,000,000	6,176	3,898	2,376	1,710	1,092	810	665	333
2,000,000/6,000,000	6,893	4,350	2,651	1,909	1,219	904	743	371

Rates for physicians employed exclusively by the Federal Government (no outside medical practice) are 25% less than those quoted above.

Rates for physicians in active military service will be quoted upon request.

To Applicants or Insured Members:

Policies issued under the State Society program bear the most appropriate of the following descriptions, omitting the explanatory data shown in parentheses. Descriptions do not need to be all inclusive. For example, General Surgery is understood to include obstetrics, incidental general practice, etc.

SPECIALTIES

Premium Class 1A

Neurosurgery
Orthopedic Surgery

Premium Class 1

Anesthesiology
General Surgery
Obstetrics and/or Gynecology
Otolaryngology, including otolaringological cosmetic plastic surgery
Plastic and Reconstructive Surgery
Vascular Surgery

Premium Class 2

Otolaryngology, exclusive of cosmetic plastic surgery
Proctology
Urology (including major surgery)

Premium Class 3

Ophthalmology (including major surgery)

Premium Class 4

Dermatology (including dermabrasion, chemobrasion and/or hair transplant)
ENT, with surgery limited to minor procedures (does not include T & A)
Industrial Medicine and minor surgery (see description under General Practice and Minor Surgery)
Neurology and/or Psychiatry (including the ordering, supervision, direction and/or performance of myelography, angiography, and/or pneumoencephalography)
Ophthalmology, with surgery limited to minor procedures
Pediatrics (not to include T & A, other major surgery or general or spinal anesthesia)
Radiology
Urology, office practice only.

Premium Class 5

Internal Medicine, including cardiac catheterization
Internal Medicine (excluding cardiac catheterization, but including cardiology, gastroenterology, rheumatology, TB and lung diseases, and endocrinology)
Allergy (including pediatric allergy)

Premium Class 6

Dermatology, exclusive of dermabrasion, chemobrasion and/or hair transplant
Industrial Medicine, exclusive of surgery (see description under General Practice, exclusive of Surgery)
Ophthalmology, exclusive of surgery

Premium Class 7

Pathology and/or Hematology
Physical medicine, rehabilitation, preventive medicine, public health
Psychiatry and/or Neurology, excluding the ordering, supervision direction, or performance of myelography, angiography, and/or pneumoencephalography.

GENERAL PRACTICE

Premium Class 6—General Practice, Exclusive of Surgery

General medicine, medical diagnostic procedures, and biopsy; minor surgery limited to incision of boils and superficial abscesses and suturing of skin and superficial fascia; splinting or casting of non-displaced fractures and fulguration of growths.

Premium Class 4—General Practice and Minor Surgery

General Practice as described under Premium Class 6; normal obstetrics, closed reduction of fractures, excision of superficial growths, assistance at major surgery for own patients.

Premium Class 3—General Practice and limited Major Surgery

General Practice as described under Premium Classes 6 and 4; non-referred major surgery limited to T & A, herniorrhaphy and hemorrhoidectomy; hospital staff appointments limited to assisting at surgery or to non-operative obstetrics.

Premium Class 2—General Practice and limited Major Surgery and/or Anesthesiology

General Practice as described under Premium Classes 6, 4, and 3; referred or nonreferred major surgery limited to T & A, herniorrhaphy, hemorrhoidectomy, and abortions; anesthesiology on a part-time basis, not to exceed an average of 12 hours per week.

A physician will *not* qualify for a General Practice category if he (1) has an active WCB specialist rating in major surgery or in anesthesiology and who does compensation work or (2) performs open orthopedic procedures or elective intra-abdominal surgery including hysterectomies, cholecystectomies or gastrectomies or (3) in the opinion of the Professional Medical Liability Insurance and Defense Board, represents a risk similar to that of a specialist.

NOTE: FOR INSURANCE PURPOSES, T & A'S AND ABORTIONS ARE CONSIDERED MAJOR SURGERY.

Table A-7. AVERAGE PAYMENT FOR CLOSED CLAIMS[1]

Year	Amount
1965	$ 5,662
1966	7,531
1967	7,704
1968	8,805
1969	8,879
1970	13,272
1971	10,112

[1] "Changes in State Society's Professional Medical Liability Insurance Program", Robert G. Hicks, M.D., *New York State Journal of Medicine*, June 15, 1972.

Claims prevention efforts have received little attention up to this time. Some educational activities are undertaken but no specified program to determine the causes of claims or their prevention has developed.

E. SOCIETY INVOLVEMENT

The Insurance Committee oversees all the group programs of the Society. The Committee meets annually with the carrier to review the entire program. Rates and reserves are discussed and graphs and charts are displayed showing the status of the plan. Other than this review procedure, the Committee undertakes no screening or peer review functions.

Contact is maintained on a day-to-day basis between the administrator of the Society and the regional office. The carrier will often notify the Society of any particular problems encountered in claims handling or underwriting matters and will often seek the advice of the Society regarding eligibility requirements.

F. PHYSICIAN-LEGAL PANEL

The Medical Society of Virginia, together with the Virginia State Bar, in 1962 developed the Joint Medico-Legal Panel for screening professional liability cases. Both physicians and attorneys realized that medical malpractice cases were tarnishing the medical profession's image. It is obvious that there are many instances of flagrant negligence, in which the injured patient is entitled to recovery. Court action in these cases is justified and the patient must be protected. However, there are also many situations in which it is not clear that the doctor may have acted wrongly. It is for these cases that the screening panel was designed.

The panel's members consist of representatives of the legal and medical professions who are members of liaison committees from the two groups. According to the Joint

Table A-8. MEDICAL SOCIETY OF VIRGINIA
PROFESSIONAL LIABILITY PROGRAM RATES, MARCH 1972

	$100/300,000 limits St. Paul	$100/300,000 limits ISO
Class I. No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	$179	$212
Class II. Minor surgery or obstetrical procedures not constituting major surgery	$314	$371
Class III. General practitioner performing or assisting in major surgery on other than their own patients, including Cardiologists who engage in catheterization but do not perform cardiac surgery. Ophthalmologists. Proctologists	$680	$805
Class IV. Specialists. Cardiac Surgeons. Otolaryngologists—no plastic surgery. Surgeons—General (Specialists in general surgery). Thoracic Surgeons. Urologists. Vascular Surgeons	$907	$1,074
Class V. Specialists. Anesthesiologists. Neurosurgeons. Obstetricians—Gynecologists. Orthopedists. Otolaryngologists—Plastic Surgery. Plastic Surgeons	$1,134	$1,342

Medico-Legal Plan for Screening Medical Malpractice Cases, Medical Society of Virginia (1967, revised), the purposes of the panel are twofold:

> . . . on the one hand, to prevent where possible the filing in court of actions against physicians and their employees for professional malpractice in situations where the facts do not permit at least a reasonable inference of malpractice; and, on the other hand, to make possible the fair and equitable disposition of such claims against physicians as are, or reasonably may be, well founded.
>
> Both professional groups recognize that the mere filing of a malpractice action in court, however unjustified medically it may be, causes substantial harm to the reputation and practice of the physician concerned. Both groups recognize, at the same time, that persons having legitimate and meritorious grievances against physicians have heretofore often encountered the greatest difficulty in substantiating their claims with expert testimony in court.

Any attorney may submit a case for consideration of the panel by addressing a request, in writing, signed by himself and his client, to the Society. The request shall contain the following:

- A brief statement of facts, i.e., claimant, dates, circumstances, and alleged acts of malpractice.
- A statement authorizing the panel to obtain access to all medical and hospital records while waiving his client's right to these records.
- An agreement that the panel hearings will be confidential and no panel members will be asked to testify.
- A request that the panel consider the merits of the claim and render its judgement to him.
- A statement that the attorney understands and has advised his client as to the panel's operation.
- A fifty dollar fee is set.

- Written consent to a review from the physician involved or if the physician does not consent, certification that the physician has been contacted.

In cases where the physician refuses to consent to a hearing, the panel may convene a unilateral hearing involving only the claimant.

Several ground rules have been established defining the panel's operation and authority:

- An equal number of attorneys and physicians for rating purposes will hear cases (currently 12 members of each profession are represented).
- The hearing will take place within 45 days of the receipt of application from the claimant.
- Interpretation of the law or discussion regarding possible damages are not within the panel's jurisdiction. The sole function of the panel is to determine if in light of the facts, negligence occurred and if the claimant was injured thereby.
- The panel will not hear cases of individuals who are not members of the Virginia Medical Society or which involve hospitals and paramedical groups.
- The Society has obligated itself to provide competent expert testimony in the event that the hearing is decided in favor of the plaintiff and results in trial.
- No official record or transcript of the hearing will be kept.

Under the original agreement in cases where the panel believed that no reasonable probability of professional negligence occurred, the attorney was asked to refrain from filing any court action *unless personally satisfied that strong and overriding reasons compel such action be taken in the interest of his client.* After ten years of operation, the panel believed this clause seriously weakened the intent of the hearings. Recently, attorneys have filed suit despite the panels determination that no reasonable probabiliy of medical malpractice occurred. In 1972, the panel heard 14 cases and almost one-half ended in filed suits. It was contended by the defendant doctor's insurance carrier (usually St. Paul) that the plaintiff's attorney was using the panel to determine the weak elements in his case and intended to file suit regardless of the outcome. In November of 1972, this situation prompted the panel to change its agreement to read:

> . . . attorneys shall thereafter refrain from filing any court action based upon that claim, and will withdraw from any court action theretofore filed for purposes of tolling the statute of limitations.

In effect, this amendment of the original clause makes the decision of the panel binding; however, the panel's decision shall not affect the claimant's or physician's right to bring a case to court. The right of legal counsel to advise the client of his rights shall remain unimpaired. Therefore, the attorney, if he believes a case meritorious, despite a negative panel ruling, while he may not file suit, may advise the client to file suit through another attorney. Nevertheless, the revision by the Committee has put some "teeth" into the arrangement

From the panel's inception to 1969, the number of cases was small, only 27, with nine decisions in favor of the patient plaintiff and 15 decisions for the defendant doctor, while three cases were settled before the hearing. Interestingly, all decisions but one were unanimous. In the last three years the number of cases brought before the panel has increased the total to about 60. Of the dozen cases pending before the revision was made, the Society believes the majority will file supplemental applications for the panel to hear their cases under the binding arrangement. Although the intent of the panel seems worthwhile, there has been some disappointment that the insurance carriers are reluctant to avail themselves of the panel, fearing that the plaintiff's attorney will take the opportunity to extract information he would not otherwise have. At the end of 1968, St. Paul had 134 professional liability claims in open status under the group plan but only a few ever went to the panel. The Society believes the new amendment will alleviate much of this fear and hope that more attorneys will utilize this service.

The panel does not hear claims involving multiple defendants and hospitals. This limitation and other functions of the panel will be studied by a special committee. One suggestion would increase the number of members on the panel in an attempt to have most of the major specialties represented. As the number of cases gets larger, the panel may want to communicate, without naming the parties involved, the facts of the cases with recommendations on how to prevent this type of incident from occurring again. Presently, no loss prevention function is served by the panel.

The Society's House of Delegates has appointed a committee to report next October on a plan of operation for a peer review foundation.[6] The committee spent this past year looking at peer review foundations in other states. In addition to utilization studies, review of standards of care, and Medicare and Medicaid claims hearings, the foundation would hear malpractice cases with only the defendant present. However, the establishment of this foundation and its functions are only being discussed at this time.

Los Angeles County Medical Association

A. DEVELOPMENT AND IMPLEMENTATION

The Los Angeles County Medical Association's (LACMA) group professional liability plan commenced in 1944 due to a chaotic situation caused by the refusal of one major insurance carrier in the area to write limits higher than $5000 per claim, and the other major carrier's policy of writing professional liability only in conjunction with other casualty insurance. The Nettleship Company was chosen as the broker and administrator of the program.

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[6] Medical foundations are found in several states, usually supported and developed by medical societies. The principal functions of a foundation are to determine the feasibility of fees, review utilization, and standards of care, identify educational needs, and in some cases to provide peer review functions. This role may vary for each individual foundation.

The original insurance carrier was the Metropolitan Insurance Company. The program immediately began to grow and as a result of this growth, the Metropolitan Insurance Company dropped the coverage, as they did not have a sufficient financial base. The Canadian Indemnity Company replaced Metropolitan. In 1951, the Canadian Indemnity Insurance Company dropped the coverage, although many of the other counties in Southern California had also adopted this program. The decision was based on Canadian Indemnity's assessment that the prospects of making a profit in malpractice insurance were poor and that the number of doctors; i.e., exposure, was straining their insurance capacity. The Zurich Insurance Company took over the program until the end of 1962. On September 24 of that year, Zurich stated that they would not renew any policies after January 1, 1963.

The Zurich Insurance Company was replaced by Pacific Indemnity of Los Angeles, effective January 1, 1963. Pacific Indemnity brought a new approach to the program through their reinsurance broker, Willcox, Baringer & Company. A pool of nine other carriers formed a "Quota Share Reinsurance" group. Each carrier shares in each loss and all expense from the first dollar. Many of the original carriers dropped out and had to be replaced. As the underwriting managers for the program, Nettleship continued to do the individual underwriting, issue policies, handle claims, and gather statistics for the carriers.

In 1968 Pacific Indemnity instituted a rate increase of nearly 100 percent. In March 1969 an Actuarial Committee was appointed, and it was agreed that actuaries from five of the insuring companies would make independent studies. The results of the studies indicated that another doubling of the rate level was necessary, and the new rates went into effect in 1969.

After the first rate increase in 1968, LACMA had approached Johnson and Higgins, a national insurance brokerage firm, to discuss acquiring a new carrier and undertaking a revamped group program. After the second rate increase in 1969, Johnson and Higgins were given the authority to proceed with a year-long study analyzing rate structure and developing a model policy.

The decision to switch carriers was primarily the result of the quadrupling in the rate level within an 18-month span. However, two other factors may have played a role. Because they believed Pacific Indemnity's administrative margins to be the lowest available, Nettleship did not attempt to replace Pacific Indemnity, which despite the losses sustained since 1963 was willing to stay with the plan. Second, the communication between LACMA and Nettleship broke down. In the chaotic period following each rate increase, LACMA believed that a full disclosure of financial data had not been made and LACMA lost confidence in the broker. Bids were sought from ten large insurance companies. Formal bids were submitted by Travelers, CNA, and the Hartford with the association finding the Hartford proposal most favorable.

The group plan under Pacific Indemnity had approximately 8000 insured physicians in the plan. When the Hartford plan went into effect on July 4, 1970, Nettleship together with Pacific Indemnity and the Imperial Insurance Company undertook a study to determine what criteria it would use to retain physicians. The study found that about 60 percent of the currently insured physicians could meet the revised criteria, and both companies attempted to retain as many of these insured as possible. As Imperial and Pacific Indemnity had differing sets of criteria, Nettleship doctors were placed with either company on the basis of the doctor's classification and experience. These two carriers are the major competitors of the Hartford group plan. The two and C.I.E. insure more than 4000 physicians in Los Angeles County.

While negotiating with the Hartford Insurance Company for a group plan for Los Angeles County, several other counties who had previously been insured with Pacific Indemnity wished to join the Hartford plan. In response to this, a legal entity called the Southern California Physicians Council was set up to allow areawide participation.

Control of the Hartford plan is maintained by the broker, which is the sole agent for selling the plan in Los Angeles County. In addition to being the sales force, the broker does all the billing, collects premiums, keeps statistical records on eligibility, classification, and claims, and basically functions as the general administrator of the plan. Perhaps the most important task of the broker is to make certain all lines of communication between the doctors, the Association, the carrier, and itself are kept open. Using the data available to them and their own actuaries and underwriters, the broker has the responsibility for recognizing impending problems, identifying developing trends, and reviewing the rate-making policies of the carrier.

B. SALIENT CHARACTERISTICS

The LACMA professional liability program is perhaps the only group program which has a master policy. This master contract written with the Southern California Physicians' Council names each individual doctor participating in the plan. The insured physician gets a certificate policy as his record of coverage. The master policy does not differ significantly from individual professional liability policies. However, it does explicitly define the understanding between the Association (in this case, the master policy is identical for the several county associations) and the carrier as to eligibility, enrollment, termination, and effective date.

The program is a comprehensive professional liability insurance plan. The basic policy certificate covers professional liability for claims incurred while practicing medicine or while acting as a member of a professional organization or board. Combined with this coverage is office premises liability insurance for bodily injury or property damage within the office. This inclusion arose from claims experience where there was difficulty in determining whether an incident involved professional or premises liability. A third area of coverage in the comprehensive plan is excess personal liability for personal injury and damages in excess of the basic policy, including coverage on automobile and watercraft. Medical expense coverage is available as an optional feature.

The arrangement under this new plan allows the Association participation in the control of the program through its broker and the Association's Medical Review Committee. The Committee participates in underwriting and claims review and is designed to give the Hartford expert appraisal on claims matters. Other features include the incorporation of interest income in rate determination, possible premium refunds, and full financial disclosure by the carrier.

C. RATING FEATURES

Minimum coverage of $100,000 is provided for every doctor named on the master policy. Excess limits of 1 million, 2 million and 5 million dollars are available on an individual basis. The Association estimates that 90 percent of physicians currently insured have coverage of 1 million or more.

Premiums vary as to the amount of coverage and the specialty of the physician. Under the plan, there are 11 different rate classifications according to specialty. Within several of these classifications are several specialties designated with the same risks; i.e., class 11 has five specialty groups—anesthesiology, orthopedic surgery, plastic surgery, obstetrics and gynecology, and neurological surgery—all rated at $729 for $100,000/300,000 limits. Additional charges are applied if the physician has any employees such as an X-ray therapist. Also, special charges are assigned to physicians who practice medicine on a part-time basis. The special charge is rated as a percentage of the basic rate according to the number of days a week the physician practices. Rate schedules are provided for partnership or medical corporation liability and umbrella coverage.

As the experience of the plan progresses, the association anticipates the number of classifications to stay the same or become fewer in number. However, as loss experience becomes more refined according to specialty groups, the placement of a specialty within any particular rate classification will change.

The most publicized feature of the new Hartford group plan in Los Angeles County was the 22 percent across-the-board rate decrease from the previous plan which had just experienced two major rate increases totaling nearly 400 percent. When the Hartford program was approved, the contract contained an 18-month rate guarantee with a ten percent increase option (later renegotiated to five percent) to be effective on January 1, 1972. After this time, the plan was to be self-rating according to loss experience. The Hartford did not increase rates in 1972. Johnson and Higgins prepared an independent actuarial analysis of the data collected since the plan's inception. After negotiations with the carrier, it was decided that an overall rate increase of 8.8 percent was necessary for 1973. Individual rates for the lower-rated specialties were reduced by 3 percent and individual rates for the higher-rated specialties were increased by 11.2 percent.[7]

It seems adjustments were in response to stiff competition between the group plan and both Pacific Indemnity and Imperial. Imperial provides the severest rate competition with lower rates in every classification. However, Imperial (and Pacific Indemnity) restricts its offerings to only selected risks and as such has insured more general practitioners than higher-risk specialties. A second factor in the group rate adjustment is the probable subsidation of the higher-risk categories by lower-risk ones within the group plan. While the extent of this possible subsidy will only be known after several years of experience, the selected risk carriers seem to skew their efforts toward the lower-risk physicians.

Another feature of the LACMA plan is the return of investment income provided for in the association's agreement. The policyholders will receive a four percent return on investment income from premiums and reserves. The return will be added to the fund for claims payment. The four percent can change, dependent upon the carrier's return and the Association's approval. An additional provision of premium return gives the program a self-rating status. For any one year's premium in which all claims are closed, the Hartford will keep its administrative costs and the increment of investment income over four percent, pay out all closed claims, and return the remaining amount to the association. Because of the long tail on claims payments, the return will be accumulated in a fund established to pay claims. Johnson and Higgins estimates that 96 percent of every experience-rated premium dollar will ultimately be available for claims and claims adjustment expense.

Claims in excess of $100,000 are not considered by the carrier in the computation of loss experience by specialty This practice prevents a few serious claims from biasing the loss experience for a specialty. These large claims are placed within the excess limits liability pool which effectively spreads the risk over the whole group.

The plan incorporates a provision for deductibles for those physicians who have experienced non-defensible claims. Depending upon the extent of fault, the physician is rated according to a point system. The points are cumulative over a five-year period. Points are also given for incurred incidents which may not lead to a claim. According to the number of points, a deductible of $1000, $2000, or $4000 is applied to the physician's coverage. The rationale used is that if a doctor realizes he may have to pay the full amount of the deductible, he may become more conscious of loss prevention. When the deductible is applied, the policy is issued at the standard rate and the doctor is not monetarily penalized until a loss is incurred. Built into this approach is an inhibitor for the doctor to report incidents since he may accumulate points for it. An attempt is made by the broker to deal with this by offering an incentive for early incident reporting.

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[7] "Professional liability insurance, 3000 members receive reducations," Los Angeles County Medical Assoc. *Bulletin*, Oct. 19, 1972, p. 12.

D. PEER REVIEW

The philosophy of the plan is to return the control of and responsibility for the program to the physician. Thus, the Medical Review Committee was formed to review the underwriting qualifications of insured physicians or new applicants; review and advise on the merits of claims, recommend action concerning substandard rating, and provide overview and direction to claims prevention.

Under the previous plan a professional liability committee existed for the sole purpose of hearing grievances and appeals on decisions concerning the defense of claims. This committee had no underwriting review powers and was used infrequently during the early years of the plan. However, with the tremendous growth in the volume of claims during the 1960's, the number of cases scheduled for review multiplied and a considerable backlog developed. One full committee had the task of reviewing all of these cases. When the Hartford group plan began in 1970, the powers and duties of the committee (renamed the Medical Review Committee) expanded and necessitated the establishment of several Medical Review Subcommittees. These subcommittees are made up of three physicians, each renumerated by the carrier for the time they spend in this responsibility.

A major task of the full committee is to review policy renewals when they come due, and to advise the carrier of any new physician applicant who desires coverage. Currently insured physicians who have experienced no claims or no complaints about their practice are automatically renewed at the standard rate. Sometimes an insured doctor will begin practicing in areas outside his previously designated specialty which will necessitate a review to determine if his classification should be changed. Any new applicants must be investigated to determine past claims experience and appropriate classification. This is usually determined from the initial application, but where claims losses have occurred previously an investigation into these claims may be necessary to determine eligibility at the appropriate rate. The committee can only make recommendations to the carrier. On very few occasions, if any, has the carrier deviated from or ignored the recommendations of the committee on underwriting matters.

When a physician has incurred a claim during the previous policy year, the committee can decide one of these things: 1) whether the physician was involved in a questionable medical practice; 2) whether the physician was at fault; or 3) whether the physician was out of the scope of his practice. This information is fed back to the underwriters, and the physician may be given a substandard rating based upon the point system described earlier.

The primary responsibility of the Medical Review Committee is to review any claim brought before it by the carrier or the physician. There are several reasons for its importance. First, it provides the carrier and the defense counsel with advice on the merit of a claim according to the medical aspects involved. The claims adjustors believe it allows them to direct their investigation to the medical areas advised by the committee. Second, peer review of claims helps to assure a doctor that a claim which is deemed non-meritorious by the committee will be fully defended. Since no case may be settled without the physician's consent, the review motivates the physician's consent in a non-defensible claim. Third, claims review uncovers the reasons for the occurrence. This information is a step toward malpractice prevention and the best way to lower professional liability insurance costs.

A review can be initiated by the carrier or defendant. Upon receiving the case, a guiding committee is available to initially review the case. This *ad hoc* committee comprised of a specialist, a head claims adjustor, and the association's attorney usually serves to eliminate many minor cases. The more involved cases where negligence is questionable are sent to a subcommittee of the Medical Review Committee composed of three physicians specialists. These subcommittees rotate members to distribute the responsibility and change specialists according to the type of practice involved in the case. If necessary, a specialist is made available as an expert witness for the defense. After the specialists review the claim, a determination usually can be made.

When the physician disagrees with the recommendation of the committee or the defense approach of the carrier, the case may be appealed to the full committee. The decision of the full committee is binding on the physician and the carrier. In this way, the committee can overrule an uncooperative physician and in effect, waive his right to final consent on settlement.

As mentioned above, the Medical Review Committee is at the Los Angeles County level. There is no district (local) society committee level; however, most local societies have one of their members on the full committee. In probing the future of the local societies in becoming involved in the peer review process, the association believes that pressures of close-knit ties between local physician colleagues may be too difficult to overcome. The expanded workload of cases to be reviewed will most likely be handled by an expanded number of subcommittees. On a long range basis, the broker estimates at least 2,000 cases on an open book basis.

E. CLAIMS HANDLING

When the program began in 1970, the Hartford set up a regional office in Los Angeles to handle the daily operations of the LACMA plan. This office has several full-time claims investigators servicing the plan. The claims process may begin under three different sets of circumstances. An incident report may be filed with the regional office alerting them to a potential claim. A copy of a letter of retention may be forwarded to the doctor by a claimant's attorney. Or, a formally-filed suit and notice to appear in court may be the first report. The most desirable method of reporting is the incident report filed by the doctor. Prompt reporting allows the claims people adequate time to minimize the potential settlement.

When an early incident report is received, the claims investigators examine the case and decide whether potential liability exists and, if so, what appropriate reserve should be set aside. On the other hand, many incidents are considered just incidents and no reserves are set up. The same process occurs when a claim is reported by an attorney or via a suit, except that liability may be imminent and a reserve must be established.

The claims manager at the regional office has personal authorization from the home office of the carrier to settle claims up to $25,000. This authority is important in the ability to render quicker negotiations and settlements and helps communication between the plaintiff's attorney and the defense counsel.

Defense counsel is retained from any one of about twelve legal firms in the Los Angeles area. No contractural arrangement exists between these firms and the association.

F. LOSS PREVENTION

The broker's role in loss prevention is maintaing and analyzing the statistical data which it receives from the carrier and the regional claims office. Trends and patterns are ascertained from these data and fed back to the association and the membership. A medical specialty communication system is now being organized for future implementation to relate important and useful scientific claim information directly to the specialty involved.

The carrier's role is to analyze the data it receives and to educate physicians to the importance of loss prevention. To facilitate this educational process, literature, films, and other educational tools are made available to the broker and the association. The association must educate and keep the members abreast of any trends which develop in medical malpractice. Printed information and lectures with local societies are the primary vehicles.

American College of Obstetricians and Gynecologists

A. DEVELOPMENT AND IMPLEMENTATION

The American College of Obstetricians and Gynecologists was founded in 1952. The College was approached in 1954 by a broker, David Richman and Associates of Chicago, who introduced the idea of starting a group plan in professional liability insurance. The College was convinced it should develop a program geared strictly for the needs of the specialty and their membership. In 1957 a group plan was initiated with the Interstate Fire and Casualty Company.

At that time, the nationwide professional liability situation for obstetricians and gynecologists was not critical although these specialties were in the highest rating classification set forth by the ISO. In most states premiums were only a few hundred dollars. New York, Florida, and California were exceptions. However, in a small number of states where there were only a few surgeons practicing these specialties, coverage was difficult to obtain. Individual carriers were reluctant to enter these states to insure only a handful of high risk surgeons.

The rationale of the group program was based on the belief that members of the College were highly trained specialists of proven skill and represented a highly select group of good risks surgeons. The group carrier would have the opportunity to become familiar with the practices and the experience gained from insuring this group would provide a basis for separating obstetricians/gynecologists from other class 5 specialists. The College did not expect the program to grow radidly, but felt it was desirable and necessary to make professional liability coverage available at reasonable rates.

Interstate remained with the group plan until 1966 when they asked the College to find a new carrier. Claims were not extremely heavy but the company desired to leave the market. The Pacific Indemnity Company was secured as the new carrier to underwrite the plan. The Nettleship Company of Los Angeles, a broker for the Pacific Indemnity, became a co-broker with Richman in administering and operating the plan. Pacific Indemnity already insured many obstetricians/gynecologists in California and New York through state and county group plans. It was decided not to market the College plan in these areas but to concentrate on the midwestern states.

B. CHARACTERISTICS

The marketing and selling of the plan are handled by Richman Associates. The various means of informing the membership of the plan are by mail, telephone, College meetings, and articles in the professional newsletter. Applications are sent to Richman, and the broker is responsible for underwriting selection. Richman is also responsible for premium collection, some claims reporting, and general services for inquiring insureds or prospects.

If any question arises as to the eligibility of a particular physician, the application is sent to the Nettleship Company who makes the final underwriting decision for Pacific Indemnity. Nettleship also keeps all statistical records including reserve status, claims losses, incidences, and rates.

Basic coverage is offered at two levels, $100/300,000 or $200/600,000. The College offers a liability insurance plan providing coverage of $1 million for professional liability, personal liability, automobile liability, and office premises liability. The underwriter for this excess coverage is Interstate National Companies.

In 1959, after a year of operation, the plan insured about 300 specialists out of a member population of 7,000 or 8,000. In 1972, there were about 14,000 physician members of the college and nearly 700 were insured in the group plan.

C. RATES

Rates assigned by Pacific Indemnity for the College's group plan typically follow ISO's advisory rates for class 5 within each state because the carrier does not have a sufficient base to rate each state individually or to file its

RATE SCHEDULE July 1, 1970

Table A-9. SOUTHERN CALIFORNIA PHYSICIANS COUNCIL PROFESSIONAL AND EXCESS PERSONAL LIABILITY INSURANCE PLAN

Medical Society	Group	Quarterly Premiums 100/300
Administrative Medicine (No Surgery)	1	190.
Allergy	1	190.
Anesthesiology	11	729.
Aviation Medicine	10	663.
Cardiovascular Disease (No Angiography)	1	190.
Cardiovascular Disease (Incl. Angiography)	3	313.
Cardiovascular Disease (Incl. Angiography & Radiation)	6	408.
Child Psychiatry (No CST)	1	190.
Child Psychiatry (Incl. CST)	2	284.
Colon & Rectal Surgery	5	383.
Diagnostic Roentgenology	1	190.
Dermatology (Incl. Radiation)	7	449.
Dermatology (Excl. Radiation)	4	330.
Family Practice (No Surgery)	1	190.
Forensic Pathology	1	190.
Gastroenterology	1	190.
General Practice (No Surgery)	1	190.
General Practice (less than 25% Surgery)	9	494.
General Practice (25% or more Surgery)	10	663.
General Preventive Medicine	1	190.
General Surgery	10	663.
Internal Medicine (No Angiography)	1	190.
Internal Medicine (Incl. Angiography)	3	313.
Internal Medicine (Incl. Angiography & Radiation)	6	408.
Neurological Surgery	11	729.
Neurology (No CST)	1	190.
Neurology (Incl. SCT)	2	284.
Obstetrics & Gynecology	11	729.
Occupational Medicine (Special Preventive Medicine)	10	663.
Ophthalmology	5	383.
Orthopedic Surgery	11	729.
Otolaryngology (Excl. Plastic Surgery)	9	494.
Otolaryngology (Incl. Plastic Surgery)	10	663.
Pathology	1	190.
Pediatrics	1	190.
Pediatric Allergy	1	190.

Pediatric Cardiology (No Angiography)	1	190.
Pediatric Cardiology (Incl. Angiography)	3	313.
Pediatric Cardiology (Incl. Angiography & Radiation)	6	408.
Physical Medicine & Rehabilitation	1	190.
Plastic Surgery	11	729.
Psychiatry (No CST)	1	190.
Psychiatry (Incl. CST)	2	284.
Public Health	1	190.
Pulmonary Diseases	1	190.
Radiology	1	190.
Radiology, Diagnostic (incl. Angiography)	3	313.
Therapeutic Radiology	8	474.
Thoracic Surgery (*rated as GS General Surgery)	10	663.
Urology	10	663.
Unspecified, Retired, Not in Practice, No Specialty Reported		
Other, Specialty No Recognized		

Additional Charges

Employee:	Physician or Surgeon	25% of Charge for Phys./Surg. Specialty if employee does not have policy in own at limits equal to employer.
Licensed Employee Technicians: Radium, Pathological or Laboratory		6.
Licensed Employee Technicians: X-Ray Therapy		17.

Special Charges

PART-TIME PHYSICIANS OR SURGEONS

A policy issued to a physician or surgeon who is employed part-time or who is in private practice part-time is to be charged a premium based upon the applicable medical specialty premium in accord with the following table:

Private Practice	Percentage of Medical Specialty Premium
1 day per week	25%
2 days per week	50%
3 days per week	75%
4 days per week	100%

For purpose of rating, each five (5) hours employed part-time equals one (1) day.

Source: Los Angeles County Medical Association own rates in every state. There are a few states in which the carrier does develop and file its own rates. Deductibles, ranging from $1,000 to $5,000, are written for physicians with a loss experience history.

D. CLAIMS HANDLING AND LOSS PREVENTION

The insured physician is asked to report all incidents to a Pacific Indemnity claims supervisor in his area. The incidents are reviewed by the supervisor and potential claims are assigned to claims adjustors for investigation. If any problems arise from a particular claim, Nettleship is informed and determines how the case should be handled. Local defense attorneys are employed. Nettleship maintains statistics on all open and closed claims which are sent to Richman and, occasionally, to the College.

The College believes that loss prevention activities are better developed and communicated through a national specialty group plan. The College has the objective of improving the quality of its members' performance. The knowledge provided by the group plan regarding the type of incidents occurring across the country allows the College to review trends and patterns and identify problem areas for its specialty. The College is able to establish procedures and communicate them through county, state, and national specialty meetings. The College publishes a newsletter which periodically contains malpractice case studies and loss prevention techniques.

E. COMMITTEE ON INSURANCE

The College's primary involvement in operating the group plan is through its Committee on Professional Liability Insurance. This Committee's primary function is to meet with the carrier and brokers at least annually to discuss rates and rate-making developments. Problems that arise in the plan are brought to the Committee, and all statistics are reviewed by it.

The Committee does not review claims and should not be compared to the peer review committees of the other group plans. However, the Committee does serve as an appeal board for any physician who wishes to present a grievance concerning his insurance status. The carrier makes the final underwriting decisions, and up to this time no physician has ever gone to the College appealing an eligibility decision. In fourteen years of operation, there has been only one cancellation and approximately five instances where a member was denied initial coverage or refused renewal.

The Committee is concerned with the impact of the malpractice problem upon the specialties of obstetrics and gynecology and the supply of specialists in these areas. In December of 1971, the College submitted to the Secretary's Commission on Medical Malpractice a position paper on professional liability which outlined the following recommendations:

1. That laws provide that the utilization of appropriately trained allied health personnel under the direction of the obstetrician-gynecologist will not increase only office patients on a part-time basis should pay proportionately for his liability coverage.
3. That local arbitration boards be considered as a method of reviewing the legitimacy of a cause of action. If a cause of action exists, these boards should be empowered to make appropriate awards.

   Provisions for appeal should be built into the arbitration system allowing for a regional arbitration group to review the decision of the lower board.

   Arbitration boards, on both the local and regional level, should consist of physicians who represent the disciplines that are involved in the cause of action, attorneys appointed by the American Bar Association and consumer advocates. Appropriate consultants may be requested to participate.
4. That consideration should be given to methods of realistic compensation approved by arbitration boards for actions brought by people after they have reached their majority.
5. That a program of no-fault insurance be developed as a method for compensation of patients for injuries sustained in the course of diagnostic procedures and treatment.
6. That restrictive consent barriers to appropriate examination and treatment of young women be removed.

Appendix B

Identification of Universe of Group Malpractice Plans and Selection of Sample

A. IDENTIFICATION OF UNIVERSE OF GROUP MALPRACTICE PLANS

The universe of group medical malpractice insurance consisted of 82 programs which were identified by NPA as being sponsored by national, state, or local medical societies or hospital associations.[8] Table C-1 lists the 82 plans and subdivides them into three categories according to type of sponsoring association:

- National medical specialty society
- State or local medical society
- State hospital association.

The procedures used in identifying each category of programs are described below.

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[8] In contrast to a "true-group" insurance program in which a single master policy is issued to the sponsoring organization and a certificate to each insured, in a "group-sponsored" program there is no master policy, but rather an individual policy is issued to each physician. There are in fact no true-group malpractice insurance programs. The role played by the organization sponsoring the insurance programs can vary considerably. While some sponsoring organizations actively participate in the program, in other cases sponsorship amounts to little more than an "endorsement," which is simply a recommendation by a medical or hospital association.

National Medical Specialty Society Plans

A total of 36 national medical societies were contacted. Included were the American Dental Association, the American Association of Medical Clinics, the American Osteopathic Association, and 33 of the 35 national medical specialty societies listed in the American Medical Association Directory (Spring, 1972).[9] All contacts were made by telephone, the respondents being asked whether the respective society endorsed or sponsored a group malpractice insurance program for its members. Of the 34 societies responding to this inquiry, 13 reported the existence of a group malpractice insurance program.

The fourteenth entry in Category 1 of Table A-1, the Student American Medical Association plan, was reported by the National Association of Insurance Commissioners. The information appearing in Columns 3 and 4 of Table B-1 was supplied by telephone respondents at the various societies.

State and Local Medical Association Plans

Thirty-one local societies of the American Medical Association offering group insurance plans were identified by the Legal Research Department of the American Medical Association. The names of carriers of these plans were also supplied in all but one case, the Alabama Association.[10] The thirty-second plan, that of the Riverside County Medical Society, came to NPA's attention via a memorandum from the insurance carrier to the Medical Malpractice Commission.

With the exception of the Alabama Medical Association plan, all local medical society plans were confirmed by an NAIC list which also supplied the date of inception of each plan (Column 3). Telephone calls were made to four of the societies randomly selected to verify the data obtained.[11] In all cases the information proved to be correct. However a telephone call made to the Medical Society of the District of Columbia, for another purpose, revealed that the Society did not presently have a plan and was in fact trying to obtain one.

In a few instances, subsequent interviews with insurance companies revealed changes in carriers which have been made during the past year. These changes have been incorporated in Column 2.

State Hospital Association Plans

According to the insurance department staff of the American Hospital Association (AHA), the United States has 7097 hospitals, approximately 6200 of which belong to the AHA. Of these, approximately 90 percent subscribe to the group malpractice insurance program offered by the local AHA society.

Two basic types of malpractice insurance coverage are available to hospitals through the AHA. The first is a plan which protects only the general interest of the hospital, i.e., the governing board, the officers, and any member of the medical review team. It does not, however, protect any other individuals who might be named in litigation.

The second type of coverage, which is purchased by approximately half of the hospitals at considerably greater expense, protects all or specific groups of hospital employees who could be named in litigation.

NPA obtained from the AHA a list of 35 state hospital associations offering group malpractice insurance plans, plus an indication of the carrier and whether the plan is endorsed or actually sponsored by the Association. These associations are listed in Table A-1 under Category III. In instances where an interview with an insurance company revealed that a change in carrier had taken place during the last year, the most recent information was reported in Columns 2 and 4. In some cases data on number of hospitals subscribing to the plan were supplied and have been incorporated into the "Remarks" section. Telephone calls to four randomly selected associations verified the data obtained from AHA headquarters.[12]

B. SELECTION OF SAMPLE OF GROUP MALPRACTICE PROGRAMS

Due to constraints of time and money, NPA was forced to limit its sample of group malpractice insurance plans to nine. In line with the case study objective of developing a taxonomy of operating procedures for group plans, it was decided that each plan would be selected on the basis of some significant unique feature.

The sample selection process was as follows. First, in the interest of comparability of data, it was decided to eliminate from the universe all group plans except those for physicians and hospitals. The national plans of the American Dental Association, the American Association of Medical Clinics and the American Osteopathic Association would no doubt make interesting case studies; but as none of these groups can be easily compared to physicians or hospitals, NPA felt that their inclusion in the sample would be distinctive and serve only to weaken the general conclusions of the report.

It was decided to divide the nine case studies between six physician plans and three hospital plans. This split seemed appropriate to NPA since the procedures used by physician group plans seemed to be more varied than those used by hospitals.

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[9] The two societies excluded from this survey were associations of government and military physicians respectively.

[10] In a subsequent interview, Employers' Mutual Insurance Company of Wausau revealed that it had recently become the carrier for the Alabama Medical Association plan.

[11] The four associations were as follows: the Medical Association of Georgia, the Minnesota State Medical Association, the Medical Society of New Jersey, and the South Carolina Medical Association. Additional information obtained in the verification calls has been incorporated into the "Remarks" section for these entries.

[12] The plans verified included those of the Iowa, Minnesota, North Carolina, and Utah Associations. Additional data obtained in these telephone calls have been incorporated into the "Remarks" section.

Having determined the universe and decided on the number of physician and hospital plans to include in the sample, NPA's next step was to gather as much preliminary data on the salient features of each of these plans as possible, in order to select the sample. Table I of an interim report by Bird Engineering to the Medical Malpractice Commission was used to ascertain which state and county associations had screening panels. Commission hearing testimony was scanned for other significant items of information on group plans.

In selecting the six physician plans it was decided that at least one national, one regional (state), and one local (county) plan should be included. Of the 14 specialty college plans, two were selected on the basis of their high risk status: The American College of Obstetricians and Gynecologists first, with the American College of Radiology selected as a replacement if necessary.

Due to the innovative rate structure given the Los Angeles County Medical Association by the Hartford Insurance Company, this group was selected as the "local" case study. The urban character of the plan was also attractive.

The remaining four state plans (Florida, Minnesota, New York, and Virginia) were selected on the basis of geographical dispersion and different insurance carriers. The final selection of six physician case studies is as follows:

Group	Carriers
American College of Obstetricians and Gynecologists, Chicago, Illinois	Pacific Indemnity
Los Angeles County Medical Society Los Angeles, California	Hartford Insurance Company
Florida Medical Association Jacksonville, Florida	Argonaut Insurance Company
Minnesota State Medical Association St. Paul, Minnesota	The St. Paul Insurance Company
Medical Society of the State of New York Lake Success, New York	Employers' Insurance of Wausau
Medical Society of Virginia Richmond, Virginia	The St. Paul Insurance Companies

Each of these state plans had at least one additional feature which made it an interesting target for study. Florida had just changed carriers, plus Dade and Broward Counties are rated separately from the rest of the State. Minnesota has an extremely high level of participation (in excess of 95 percent) and had a medical review panel since 1955, New York has one of the oldest plans (since 1921), as well as the largest physician plan (21,000 physicians), it also has a review panel, and Virginia has a panel which some insurers reportedly do not like to use.

Three state hospital association plans were selected on the basis of size, interesting features, differing insurers, and whether the plan was sponsored or endorsed. The selected plans, size, type, and carrier were:

Plan	Size/Type	Carrier
California Hospital Association Sacramento, California	400 hospitals out of 600 in state/sponsored	Farmer's Group
Hospital Association of Pennsylvania, Camp Hill, Penn.	unavailable[13]/ endorsed	Employers' Mutual of Wausau
Texas Hospital Association Austin, Texas	200 out of 425 sponsored	Argonaut

In addition, the Southern California hospitals have an arbitration system.

C. ADDITIONAL GROUP MALPRACTICE PLANS

During the course of subsequent interviews conducted with insurance carriers, NPA staff members learned of a number of additional group malpractice plans, many of them brand new. These additional plans are listed in Table B-2.

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[13] Mr. R. P. Bergen, of the AMA, believes the participation rate to be significant.

Table B-1. FIRST ROUND GROUP MEDICAL MALPRACTICE INSURANCE PLANS

I. NATIONAL MEDICAL ASSOCIATION PLANS

	ASSOCIATION	CARRIER	DATE OF INCEPTION OF CURRENT PLAN
1.	American Academy of Dermatology	Fidelity and Casualty	1967
2.	American Association of Medical Clinics	Continental Insurance Co. of North America	1971
3.	American College of Allergists	Fidelity and Casualty	1967
4.	American College of Ophthamologists and Laryngologists	Fidelity and Casualty	1967
5.	American College of Obstetricians and Gynecologists	Pacific Indemnity	1967
6.	American College of Physicians	Liberty Mutual	1959
7.	American College of Radiology		
8.	American Dental Association	Pacific Indemnity	
9.	American Osteopathic Association	Pacific Indemnity	
10.	American Psychiatric Association	Pacific Indemnity	
11.	American Society of Abdominal Surgeons		
12.	American Urological Society	Professional Insurance of New York	1965
13.	College of American Pathologists	Travelers Insurance Co.	within last 5 years
14.	Student American Medical Association	Casualty and Indemnity Exchange	1969

II. STATE AND LOCAL MEDICAL ASSOCIATION PLANS

	ASSOCIATION	CARRIER	DATE OF INCEPTION OF CURRENT PLAN
1.	Medical Association of the State of Alabama	Employers' Mutual of Wausau	
2.	Arizona Medical Association, Inc.	Travelers Insurance Co.	1971
3.	Arkansas Medical Society[1]	St. Paul Insurance Co.	1950's
4.	Colorado Medical Society	Hartford Insurance Group	1971
5.	Connecticut State Medical Society	Aetna Life and Casualty	1971
6.	Medical Society of the District of Columbia[1]	St. Paul Insurance Companies	1955
7.	Florida Medical Association	Argonaut	1972
8.	Medical Association of Georgia	St. Paul Insurance Companies	1955
9.	Hawaii Medical Association	Argonaut	1971
10.	Idaho Medical Association	Argonaut	1971
11.	Illinois State Medical Society	Employers' Fire Insurance Co.	1968
12.	Louisiana State Medical Society[1]	St. Paul Insurance Companies	1950's

13.	Medical and Chirurgical Faculty of Maryland	St. Paul Insurance Companies	1950's
14.	Massachusetts Medical Society	Argonaut	1972
15.	Minnesota State Medical Association	St. Paul Insurance Companies	1956
16.	Mississippi State Medical Association	St. Paul Insurance Companies	1950's
17.	Nebraska Medical Association[1]	St. Paul Insurance Companies	1972
18.	Medical Society of New Jersey	Pacific Indemnity	1971
19.	New Mexico Medical Society	Travelers Insurance Co.	1971
20.	Medical Society of the State of New York	Employers' Insurance of Wausau	1949
21.	Medical Society of the State of North Caroline[1]	St. Paul Insurance Companies	1956
22.	Oklahoma State Medical Association	Insurance Co. of North America	1966
23.	Oregon Medical Association	Continental Insurance Co. of North America	1971
24.	Pennsylvania Medical Society	Argonaut	1971
25.	Rhode Island Medical Society[1]	St. Paul Insurance Companies	1950's
26.	South Carolina Medical Society[1]	St. Paul Insurance Companies	1950's
27.	Tennessee Medical Association	Shelby Mutual Insurance Co.	1954
28.	Medical Society of Virginia	St. Paul Insurance Companies	1956
	CALIFORNIA		
29.	Alameda-Contra-Costa Medical Association	American Mutual Liability Insurance	1945
30.	Los Angeles County Medical Association	Hartford Insurance Co.	1970
31.	San Diego County Medical Association	Continental Insurance Co. of North America	1970
32.	Riverside County Medical Society	Continental Insurance Co. of North America	1971

III. STATE HOSPITAL ASSOCIATION PLANS

	ASSOCIATION	CARRIER	DATE OF INCEPTION OF CURRENT PLAN
1.	Alabama Hospital Association (E)	Argonaut	1966
2.	Arizona Hospital Association (E)	Truck Insurance Exchange (Farmer's Group)	
3.	Arkansas Hospital Association (E)	Argonaut	1968
4.	California Hospital Association (S)	Argonaut	1954
5.	Colorado Hospital Association (E)	St. Paul Insurance Co.	
6.	District of Columbia Hospital Association (S)	Argonaut	
7.	Florida Hospital Association (S)	Argonaut	1970
8.	Georgia Hospital Association (E)	Argonaut	1965
9.	Hospital Association of Hawaii (E)	Argonaut	1963
10.	Idaho Hospital Association (S)	Argonaut	1970
11.	Indiana Hospital Association (S)	Argonaut	1961
12.	Iowa Hospital Association (S)	Argonaut	1971
13.	Kansas Hospital Association (E)	Argonaut	1967
14.	Kentucky Hospital Assocation (E)	Argonaut	1959
15.	Louisiana Hospital Association (E)	Argonaut	1964
16.	Massachusetts Hospital Association (S)	Argonaut	1972
17.	Michigan Hospital Association (E)	Argonaut	1966
18.	Minnesota Hospital Association (S)	Argonaut	1959
19.	Mississippi Hospital Association (S)	Argonaut	1970
20.	Missouri Hospital Association (E)	Argonaut	1964
21.	Montana Hospital (E)	State Farm	

22.	Nebraska Hospital Association (E)	Argonaut	1966
23.	Nevada Hospital Association (E)	Truck Insurance Exchange (Farmer's Group)	
24.	New Hampshire Hospital Association	Truck Insurance Exchange (Farmer's Group)	
25.	New Jersey Hospital Association (S)	Argonaut	1966
26.	Hospital Association of New York State (S)	Argonaut	1971
27.	North Carolina Hospital Association (S)	Employers' Mutual of Wausau	
28.	Oregon Association of Hospitals (S)	Truck Insurance Exchange (Farmer's Group)	
29.	Hospital Association of Pennsylvania (E)	Employers' Mutual of Wausau	
30.	South Carolina Hospital Association (S)	Employers' Mutual of Wausau	
31.	Tennessee Hospital Association (S)	Argonaut	1961
32.	Texas Hospital Association (S)	Argonaut	1967
33.	Utah State Hospital Association (S)	Insurance Co. of North America	
34.	Virginia Hospital Association (S)	Employers' Mutual of Wausau	
35.	Washington State Hospital Association (S)	Argonaut	1971
36.	Wisconsin Hospital Association (E)	Employers' Mutual of Wausau	

[1] Identified from sources other than the American Medical Association's list.

[2] (E) designates endorsed plans. (S) designates sponsored plans.

Table B-2. ADDITIONAL GROUP MEDICAL MALPRACTICE PLANS

STATE AND LOCAL MEDICAL ASSOCIATION PLANS

Association	Carrier	Date of Inception of Plan
Delaware Medical Association	Aetna Life and Casualty	1971
Montana Medical Association	Aetna Life and Casualty	1972
Utah Medical Association	Aetna Life and Casualty	1971
Washington Medical Association	Aetna Life and Casualty	1971
West Virginia Medical Association	Aetna Life and Casualty	1972
Wyoming Medical Association	Aetna Life and Casualty	

STATE AND LOCAL HOSPITAL ASSOCIATION PLANS

Illinois and Chicago Hospital Association		1961

OTHER ASSOCIATION PLANS

New York State Dental Association	Lumberman's Mutual Casualty Company	
Tennessee Dental Association	Shelby Mutual Insurance Company	
American Federation of Licensed Practical Nurses	St. Paul Insurance Company	
California Nurses Association	Continental Insurance Company of North America	
Illinois Nurses Association	St. Paul Insurance Company	
Kansas Nurses Association	St. Paul Insurance Compay	
New York State Nurses Association	Professional Insurance Company of New York	
Oklahoma Nurses Association	St. Paul Insurance Company	

Florida Osteopathic Association	Professional Insurance Company of New York
New Jersey Osteopathic Association	Professional Insurance Company of New York
National Association of Residents and Interns	Employers' Mutual of Wausau

Source: Interviews with insurance carriers.

Appendix C
The Universe of Medical Malpractice Insurers and the Sample Selection

A. THE UNIVERSE OF MEDICAL MALPRACTICE INSURERS

The universe of malpractice insurers was obtained from three sources: those insurance carriers identified by the Malpractice Commission as writers of malpractice insurance; all insurance carriers which report malpractice loss premium information to the Insurance Services Organization; and any insurance carrier identified with this area from a survey of the malpractice literature. The Commission's list was revealed to contain all known major malpractice carriers as well as some minor ones. ISO is the principal statistical reporting organization and rating bureau for malpractice insurance from which data are actually available. Most minor carriers report to ISO in order to use their rates. Thus, the combination of the Commission's and the ISO's lists plus those firms identified in the literature survey results in a good approximation of the universe of malpractice insurers. The universe is displayed in Table D-1.

B. SAMPLE SELECTION

The 21 firms selected for a personal interview include the top ten insurers (as determined by a Commission study) in terms of 1970 claims received or premiums written (or both). Also included were any insurers which had an associated actuary who specialized in malpractice.[14] These three criteria determined twelve firms for inclusion. To reduce travel costs and save production time, the remaining nine firms included in the initial sample were selected on the basis of their proximity to the first twelve firms. The mail questionnaire was sent to all other firms identified as part of the universe.[15]

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[14] It was thought that the presence of such an actuary would indicate that the insurer was either a large volume malpractice writer prior to 1970 or was planning to increase its malpractice activities in the future. In either case, it was thought that the information from such an insurer would be most valuable.

[15] There was one ommission due to an explicit request from a carrier.

Table C-1. THE UNIVERSE AND LOCATION OF MEDICAL MALPRACTICE INSURERS

* 1. Aetna Casualty and Surety Company
151 Farmington Avenue
Hartford, Connecticut 06115
(203) 173-0123
2. Agricultural Insurance Company
(formerly American Empire
Insurance Company of South Dakota)
215 Washington Street
Watertown, New York 13601
(315) 788-5000
3. American Fidelity Fire Insurance Company
100 Crossways Park, W.
Woodbury, New York 11797
(516) 364-2700
* 4. American Home Assurance Company
102 Maiden Lane
New York, New York 10005
(212) 344-9200
* 5. American Mutual Liability Company
Wakefield, Massachusetts 01880
(617) 245-6000
6. American Universal Insurance Company
144 Wayland Avenue
Providence, Rhode Island 02904
(401) 351-4600
* 7. Argonaut Insurance Company
250 Middlefield Road
Menlo Park, California 94025
(415) 326-0900
8. Casualty Indemnity Exchange
1600 Broadway
Denver, Colorado 80202
(303) 898-9797
* 9. Continental Casualty Company
310 South Michigan Avenue
Chicago, Illinois 60604
(312) 822-5000
*10. Continental Insurance Company
80 Maiden Lane
New York, New York 10038
(212) 553-8080
11. Empire Casualty Company
3950 East Exposition Avenue
Denver, Colorado 80209
(303) 722-2843
12. Employers Casualty Company
Employers Insurance Building
Dallas, Texas 75202
(214) 742-9331
13. Employers Commercial Union Group, Boston, Mass.
(merged with Employers Commercial
Union Insurance Company on March 31, 1971)
*14. Employers' Mutual Liability Insurance
Company of Wausau
2000 Westwood Drive
Wausau, Wisconsin 54401
(715) 845–5211
15. Fidelity and Casualty Company
80 Maiden Lane
New York, New York 10038
(212) 553-8080
*16. Fireman's Fund Insurance of California
3333 California Street
San Francisco, California 94119
(415) 567-5000
17. Forum Insurance Company
15 Westminster Street
Providence, Rhode Island 02903
(401) 861-2400
18. General Accident Fire and Life Assurance
Corporation, Ltd.
(General Accident Group Insurance Company)
Perth, Scotland
U.S. Branch: 4th & Walnut Streets
Philadelphia, Pennsylvania 19106
(215) 238-3000
19. General Casualty Company of Wisconsin
117 East Wilson Street
Madison, Wisconsin 53701
(608) 257-1431
20. Great American Insurance Company
6310 San Vicente Boulevard
Los Angeles, California 90048
(213) 937-8000
21. Gulf Insurance Company
3015 Cedar Springs Road
Dallas, Texas 75219
(214) 526-5281
*22. Hartford Accident and Indemnity Company
Hartford Plaza
Hartford, Connecticut 06115
(203) 547-5000
*23. INA Reinsurance Company
1600 Arch Street
Philadelphia, Pennsylvania 19101
(215) 241-4000
*24. Leatherby Insurance Company
1400 North Harbor Boulevard
Fullerton, California 92632
(714) 879-8903
25. Liberty Mutual
175 Berkeley Street
Boston, Massachusetts 02117
(617) 357-9500
*26. Lumberman's Mutual Casualty Company
Longrove, Illinois 60049
(312) 540-2000
27. Maryland American Insurance Company
2727 Allen Parkway
Houston, Texas 77019
(713) 522-1111

28. Maryland Casualty Company
3910 Keswick Road
Baltimore, Maryland 21211
(301) 366-1000
29. Medical Protective Company
5814 Reed Road
Fort Wayne, Indiana 46805
(219) 485-9622
30. Minnesota Mutual Fire and
Casualty Company
10601 Wayzata Boulevard
Minnetonka, Minnesota 55343
(612) 544-3681
31. National Auto and Casualty
Insurance Company
639 South Spring Street
Los Angeles, California 90014
(213) 626-9552
32. New Hampshire Insurance Company
1750 Elm Street
Manchester, New Hampshire 03104
(603) 669-6300
33. Northern Insurance Company of New York
P.O Box 91
Baltimore, Maryland 21203
(301) 366-1000
34. Northwestern National Insurance Company
731 North Jackson Street
Milwaukee, Wisconsin 53202
(414) 271-8570
35. Ohio Casualty Insurance Company
136 North Third Street
Hamilton, Ohio 45025
(513) 867-3000
*36. Professional Insurance Company of New York
90 Park Avenue
New York, New York 10016
(212) 687-2110
37. Puerto Rican American Insurance Company
P.O. Box 112
San Juan, Puerto Rico 00902
(809) 725-6500
38. Reliance Insurance Company
4 Pennsylvania Plaza
Philadelphia, Pennsylvania 19103
(215) 864-4000
39. Reserve Insurance Company
65 East South Water Street
Chicago, Illinois 60601
(312) 641-6300
40. Royal Globe Insurance Company
10 South Riverside Plaza
Chicago, Illinois 60606
(312) 263-3701
41. Security Insurance Company of Hartford
1000 Asylum Avenue
Hartford, Connecticut 06101
(203) 278-1000
42. Security Mutual Casualty Company
222 South Riverside Plaza
Chicago, Illinois 60606
(312) 621-4500
*43. Shelby Mutual Insurance Company
of Shelby Ohio
19 Mansfield Avenue
Shelby, Ohio 44875
(419) 347-1880
*44. Signal Insurance Company
(Imperial Insurance Company)
417 South Hill Street
Los Angeles, California 90013
(213) 625-0431
45. Southern Home Insurance Company
112 South Main Street
Greer, South Carolina 29651
(803) 877-3311
46. State Farm Fire and Casualty Company
112 East Washington Street
Bloomington, Illinois 61701
(309) 662-2311
*47. St. Paul Fire and Marine
Insurance Company
385 Washington Street
St. Paul, Minnesota 55102
(612) 221-7911
48. TransAmerican Insurance Company
(formerly Pacific National)
1150 South Olive Street
Los Angeles, California 90015
(213) 749-3051
*49. Travelers Indemnity Company
One Tower Square
Hartford, Connecticut 06115
(203) 277-0111
*50. Truck Insurance Exchange
(Farmers Group)
4680 Wilshire Boulevard
Los Angeles, California 90051
(213) 931-1961
51. Underwriters at Lloyds, London
Lime Street
London EC3M 7HA England
Illinois office: 135 South LaSalle St.
Chicago, Illinois 60603
(312) 786-6314
52. Union Insurance Society of Canton, Ltd.
British Crown Colony of Hong Kong
U.S. Branch: 59 John Street
New York, New York 10038
(212) 233-0560
*53. United States Fidelity and Guaranty
United States Fidelity and Guaranty Building
Baltimore, Maryland 21203
(301) 359-0380

54. Western Casualty and Surety Company
14 East First Street
Fort Scott, Kansas 66701
(316) 223-1100
55. Interstate Fire and Casualty Company
175 West Jackson Boulevard
Chicago, Illinois
56. The Buckeye Union Insurance Company
111 East Broad Street
Columbus, Ohio 43216
57. California Union Insurance Company
16th and Parkway
Philadelphia, Pennsylvania 19101
58. The Hawaiian Insurance and Guaranty Company
720 Kapiolani Boulevard
Honolulu, Hawaii 96813
59. Triton Insurance Company
617 Delaware Street
Perry, Oklahoma 73077
60. United States Fire Insurance Company
110 William Street
New York, New York 10038
61. Physicians and Surgeons Underwriters
Insurance Company
635 9th Street
Minneapolis, Minnesota 55402
62. American Motorists Insurance Company
Sheridan Road at Lawrence Avenue
Chicago, Illinois 60640
*63. Kaiser Foundation Health Plan
300 Lakeside Drive
Oakland, California 94604
64. Employers Fire Insurance Company
65. Employers Surplus Lines Insurance Company
110 Milk Street
Boston, Massachusetts
66. Gulf American Fire and Casualty
2525 East South Boulevard
Montgomery, Alabama
67. Erie Insurance Exchange
144 East 6th Street
Erie, Pennsylvania 16507
68. Professional Mutual Insurance Company
3527 Broadway
Kansas City, Missouri 64111

Source: Secretary's Commission on Medical Malpractice, DHEW; and Insurance Services Organization.

*Those insurers who were interviewed or included in the mail survey.

AN AMERICAN HOSPITAL ASSOCIATION PROFESSIONAL LIABILITY INSURANCE SURVEY

William R. Pabst, Ph.D.

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I. Introduction

During the summer of 1972, the American Hospital Association conducted a mail survey of many aspects of professional liability insurance among its member hospitals. The National Hospital Panel Survey Sample was used, with a questionnaire being sent to a total of 980 hospitals. Replies were received from about 43%, but city, state, and county hospitals were excluded from the tabulations because of the inapplicability of questioned procedures to these institutions.[1] The 270 hospitals whose replies are tabulated are projected to a universe of 4,113 non-governmental hospitals. These 4,113 hospitals contained 657,851 beds, had a daily census of 546,048 patients (including out-patient adjustment), and had 23,602,850 admissions in 1971. This universe is thus less than the United States total of 7,123 hospitals, with 1,616,000 beds, daily census of 1,298,000 and admissions of 31,759,000 as given in the AHA statistics for 1970. (See *Hospitals* Vol. 45, Part 2, August 1, 1971, p. 447.)

The survey covered the number of professional liability claims filed against the hospitals in recent years, the number of claims paid and the dollars involved, the amount of insurance coverage, the premiums paid, and other insurance details. The data tabulated from the replies is classified in the appended tables, according to hospital

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[1] The relatively small response rate may suggest some bias or non-sampling error since it might be surmised that only those interested in the subject might have been motivated to answer the rather complex questionnaire. Those with most direct contact with professional liability problems might have responded. The comparisons from year to year for different hospital types are not likely to be affected.

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size. The Association warns that the figures are estimates and that they have many limitations. These limitations will be discussed with respect to each subject heading. The complexity of the subject matter, coupled with the data limitations, make it necessary to qualify most of the findings and conclusions, but it is reassuring that those details that can be substantiated from other sources, such as the number of claims, are substantially confirmed.

II. Findings

1. The number of professional liability or malpractice claims against hospitals either as sole defendant or as co-defendant increased from the 1967 year of incidence to the 1970 year by more than 75%, going from 1.026 to 1.862 claims filed per hospital. As of this time, the year 1971 shows only 1.732 claims per hospital but it is possible that more claims based on that year will still be filed. For the year 1970, which should be substantially complete, the total claims filed were divided between 1.083 sole defendant, and 0.779 co-defendant claims filed per hospital for that year.

2. For 1970 incident year, the total sole and co-defendant claims filed of 1.862 per hospital can be equated to 1.2 per 100 hospital beds, or 3.8 per 10,000 patient census days.

3. The data reported on the number of multiple claims per hospital show that most of the hospitals have a claims-filed rate that is much, much lower than the average. This information leads to the tentative conclusion that a reduction in the claims filed rate of 10% of the hospitals could lower the average rate by a half or even less. (see IV-4)

4. During the 5-year period, a total of 13.6 thousand claims paid was reported with an average of about $2,200 per claim paid (number of claims paid per hospital times number of hospitals for all years). Possibly the long-delayed, more expensive claims accruing to the incident year may raise these averages considerably.

5. The premium cost for basic professional liability coverage was reported as $13,689 per hospital in 1970, $15,231 per hospital in 1971, and $20,466 per hospital in 1972, an increase in premium cost of approximately 50% over these three years. Some of this may be explained by an increase in basic coverage, 65% of the hospitals having coverage of $10,000 or less in 1970 and only 50% of them having this coverage in 1972. Excess and umbrella premiums added $2,776 per hospital in 1970, $3,819 per hospital in 1971, and $3,692 per hospital in 1972, making a total cost of $68.4 million, $78.3 million, and $103.5 million in the three years, respectively.

6. The total premiums for professional liability coverage with excess and umbrella coverage of $25,000 per hospital, as of 1972, amounts to $158 per hospital bed, or 52 cents per patient census day. Since each hospital had in 1970, considered to be the last complete year, an average of 1.862 sole and co-defendant claims filed, the malpractice insurance costs amount to approximately $13,400 per claim filed.

7. Reserves per claim outstanding over the 5 years amount to approximately $14,000 per claim.

III. Number of Claims

1. NUMBER

The estimated total number of professional liability or malpractice claims filed against all hospitals for incidents occurring during 1970 was 7,738, 4,500 being sole defendant and 3,238 being co-defendant claims. This estimate of 7,738 claims filed can be viewed as:

- 1.9 claims filed annually per hospital (for 4,113 hospitals included in the universe)
- 1.2 claims filed per 100 hospital beds (for 657,851 hospital beds)
- 3.1 claims filed per 10,000 hospital admittances (for 23,602,850 admittances)
- 3.8 claims filed per 10,000 patient census days (for 546,048 daily census)

These numbers are not large in relation to many other social phenomenon, for they are dwarfed by the millions insured in motor vehicle accidents (some 55,000 deaths) and by the 7.6 million involved in consumer product accidents sufficient to warrant hospital emergency room treatment. This number of claims is also very small in comparison with the number of iatrogenic injuries, that is, injuries arising from medical attention, which have been estimated to amount to from 5 to 8 per cent of hospital charts examined.[2] The number of malpractice claims filed against the hospitals in 1970 is about one for every two hundred iatrogenic injuries using the lower estimate.

2. NUMBER PER SIZE OF HOSPITAL

The number of malpractice claims per hospital bed appears to be larger for the large and medium hospitals than for the small ones.

3. TREND IN NUMBER OF CLAIMS

The number of malpractice claims filed against the hospitals increased from 4,395 in the 1967 incident year to 7,738 in 1970, an increase of over 75% in the 4 year period. This assumes that all of the claims related to 1970 incidents have been filed. The number of claims has increased at about the same rate for all sizes of hospitals except the very small (6-99 beds) group. In these small ones, there has been no apparent increase at all. The tabled data indicate a lower number of co-defendant claims for 1971 than for the previous years, but this may arise from the known lag in filing claims, especially since the hospital may not be mentioned at all until a claim initiated against some other party has moved from the claim stage to that of being an actual suit. The great increase in the number of claims came in the years from 1967 to 1969, but because of the time delay in discovery it is too early to state that the trend has levelled off.

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[2] See "The Incidence of Iatrogenic Injuries", *supra*, pp. 50 ff.

Part of the increase in the number of claims filed in 1969, 1970, and 1971 may come from a change in the nature of the claims, possibly more trivial incidents being established as claims.

4. THE DISTRIBUTION OF HOSPITALS HAVING MULTIPLE SOLE DEFENDANT CLAIMS

In the 4,113 hospitals in the universe, 69.1% were indicated as having no sole defendant claims in 1971 (the only year for which distribution of hospital by number of claims was given). The tabulations also show that 10.1% of the hospitals had one claim, another 6.4% had two claims, and finally that 0.3% (10 hospitals) had over 20 claims. Since there were a total of 4,719 sole defendant claims reported in this year, an average of 1.15 claims per hospital, the question that we might ask is whether this distribution is one that might be expected if the claims were randomly assigned by some unseen hand among the hospitals involved. To throw light on this question, one turns to the well-known Poisson distribution using for the expected number the value 1.15, to get the expected percentages shown in the table below. The observed values indicated are those reported from the survey, as follows:

Hospitals having Sole Defendant Malpractice Claims in 1971, showing the number having none, and one and more, based on 4,719 claims reported from 4,113 hospitals (a rate of 1.15 claims per hospital)

Number of Claims per Hospital	Observed percentage in survey	Expected percentage from Poisson Distribution
no claims	69.1	33.0
one claim	10.1	37.0
two claims	6.4	20.0
three claims	4.0	7.0
four claims	1.7	2.5
five claims	2.5	0.4
over five	6.2	0.1
	100.0	100.0

The difference between the observed and the expected is striking. Instead of 69.1% of the hospitals having no claims, we would expect only 33.0%. This means that most of the hospitals are doing better than could be expected on the basis of the average claims rate of 1.15 per hospital. In fact, to be consistent with the 69.1% of the hospitals having no claims, a claim rate of only 0.35 per hospital year is indicated, that is, only about a third of the average rate now observed. On the other end of the scale, we would expect only one hospital in a thousand to have more than 5 claims, but unfortunately we observe 6.2% (or about 253 of them) to have 5 or more claims. The hypothesis that this establishes is that whereas most hospitals are much better than average, there are a few hospitals with so many multiple claims that they drag the average down.

Were the breakdown data available, this analysis could be made for each size of hospital. These conclusions are substantiated by inspection for each of the 4 size-groups of hospitals; in each group the few hospitals having a large number of claims tend to drag the average down, making the claim rate of the average hospital appear to be much worse than it really is.

The data are not yet tabulated for the prior years or for the combined sole and co-defendant data to make a similar analysis, but the presumption is that the same situation applies. This provides a fruitful field for study, to ascertain whether those hospitals having multiple claims are repeating from year to year. If this were found to be the case, one can easily see from the survey data presented that an improvement in 10% of the hospitals could reduce the existing rate of claims to one-third or one-half of what it is.

IV. Claims Paid and Payments

1. NUMBER OF CLAIMS PAID

The number of claims reported paid "by your hospital or by your insurance companies" for incidents in 1967 was 2,579, as against the total number of sole defendant and co-defendant claims of 4,395. The claims paid in that year were thus 59% of the total claims reported. In the following years 1968, 1969, 1970 and 1971, the percentage of claims paid to total claims were 62%, 42%, 37%, and 29% respectively. This falling off in the percentage of claims paid can be related to a number of things, among which are the increase in claims outstanding, the effect of the usual "long tail" in claims settlement, and as indicated above, an increase in the number on which no payment was or is to be made.

2. TREND OF CLAIMS PAID

Because of the factors indicated above, no trend is discernible in the number of claims paid. The number increases slightly from 1967 through 1969, but then falls off because of the many factors indicated. Some time may pass before the total number of claims paid on the incidents in these later years is known with some certainty.

3. TREND IN HOSPITALS HAVING CLAIMS

Eight hundred sixty-one hospitals, 22.3% of the 4,282 included in the universe, had one or more sole defendant[3] claims in 1967; 1,256 hospitals or 29.3% had one or more sole defendant claims in 1970. The number of hospitals having some claims has thus increased about 50% during this interval. The reflection of this is that the number of hospitals having no claims at all filed upon the incidents of that year decreased from 77.7% in 1967 to 69.8% in 1970, and provisionally to 69.1% in 1971. Although most of the hospitals get through each year without a claim filed, the tabulations show what one might expect, that the smaller hospitals have a better record of getting through unscathed. In 1971, 91.7% of the very small (6-99 beds) hospitals had no claim-producing incidents (as yet revealed), whereas only 58.5% of the small (100-299 beds), 22.6% of the medium (300-499 beds), and 32.9% of the large (500 beds and over) went without a malpractice claim. To have a large 500-bed hospital go without a sole defendant malpractice claim for a year is not surprising since in view of the average rate of 1.15 sole defendant claims indicated above, we might expect 33% of the hospitals to have no claims in a year.

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[3] Sole defendant claims implies that the hospital is the *only* defendant. Co-defendant claims implies that some one other than the hospital, usually a physician, is also a defendant. The estimate for sole defendant claims is slightly inflated since claims were included as sole defendant claims if hospitals were not able to report claims by type.

The trend of co-defendant claims filed, kept distinct in the tabulations from the sole defendant claims discussed above, shows a slightly more volatile increase in these years, with the number of hospitals with one or more co-defendant claims rising from 508 in 1967 to 990 in 1970. The number in 1971 is lower, possibly because of the lag in discovery of claims. The relatively more rapid increase in co-defendant claims may reflect the increase in malpractice claims against physicians in which the hospital is named as the case moves from the claim into the litigation phase.

4. SOLE AND CO-DEFENDANT CLAIMS

Although the combined data for the number of hospitals having both sole and co-defendant claims was not available when the above was written, the analysis comparing observed against expected numbers will give even more dramatic evidence that most hospitals are better than average. The combined table suggests that the hospital having multiple sole claims, for the large part, had multiple co-defendant claims as well.

Appended Tables

AMERICAN HOSPITAL ASSOCIATION PROFESSIONAL LIABILITY INSURANCE SURVEY

The basic tables from which the above findings are extracted are given here to allow those who wish to study them in greater detail. There is a great need for both a more complete analysis of the present data, and for additional information on this general subject from the hospitals.

The Hospital Professional Liability Insurance Survey was sent to 890 hospitals participating in the National Hospital Panel Survey. Approximately 43 per cent of these hospitals responded. City, state, and county hospitals were excluded before universe estimates were made. Estimates are based on the following number of hospitals:

6 - 99 beds	84
100 - 299 beds	82
300 - 499 beds	32
500 or more	72
Total hospitals	270

It is important for the user of the data to be aware that the figures are estimates based on a small sample of hospitals and that the data have some limitations. The reliability of the variables is reflected in the tables of means and standard errors. Estimates are based on the assumption that all nonresponding hospitals have basic professional liability insurance coverage. About one-fifth of the hospitals were telephoned to check on data that seemed inconsistent. In those cases where insurance agents completed the questionnaire it was assumed that the data were correct. Some hospitals had difficulty determining whether a policy was an excess or an umbrella policy. Also the umbrella policy reported by some hospitals probably covers more than professional liability insurance. Dollars of claims paid does not accurately reflect cost of defense or investigation since many hospitals did not have this information. The estimate of the number of sole-defendant claims is slightly inflated since claims were included as sole-defendant claims if hospitals were not able to report claims by type. No hospitals were fully self-insured or had complete immunity status in 1972. Since some hospitals had immunity status prior to 1972, the projections for the earlier years are less reliable.

HOSPITAL PROFESSIONAL LIABILITY INSURANCE PREMIUMS MEANS AND STANDARD ERRORS

Type of Premium		All Hospitals	
		M	SE
Basic	1970	13,689	830
	1971	15,231	1,286
	1972	20,466	1,177
Excess	1970	950	252
	1971	1,233	347
	1972	1,432	383
Umbrella	1970	1,826	158
	1971	2,586	205
	1972	3,260	223

Bureau of Research Services, American Hospital Ass'n.
LR: 12/13/72

HOSPITAL PROFESSIONAL LIABILITY INSURANCE CLAIMS MEANS AND STANDARD ERRORS

Type of Claim	All Hospitals	
	M	SE
Hospital Sole Defendant		
1967	.675	.092
1968	.859	.144
1969	1.058	.185
1970	1.083	.118
1971	1.147	.124
Hospital Co-Defendant		
1967	.351	.085
1968	.573	.111
1969	.678	.114
1970	.779	.117
1971	.585	.112

Bureau of Research Services, American Hospital Ass'n.
LR:12/13/72

HOSPITAL PROFESSIONAL LIABILITY INSURANCE CLAIMS MEANS AND STANDARD ERRORS

Type of Claim	All Hospitals	
	M	SE
No. Claims Paid		
1967	.602	.084
1968	.743	.090
1969	.762	.089
1970	.697	.084
1971	.495	.066
Dollars Claims Paid		
1967	2,568	664
1968	2,349	371
1969	1,896	482
1970	2,414	1,081
1971	1,510	451
Dollars in Reserve		
1967	2,070	1,008
1968	3,036	1,019
1969	6,663	2,965
1970	6,826	1,748
1971	11,260	4,148
No. Claims Outstanding		
1967	.131	.023
1968	.277	.044
1969	.417	.049
1970	.667	.067
1971	.755	.072

Bureau of Research Services, American Hospital Ass'n.
LR:12/13/72

HOSPITAL PROFESSIONAL LIABILITY INSURANCE

	1970*		1971*		1972*	
	No.	Percent	No.	Percent	No.	Percent
Short-term Nongovernmental Hospitals	4155	100.0	4113	100.0	4113	100.0
Basic Coverage Premiums						
$1000 & Under	334	8.0	281	6.8	206	5.0
1001 - 5000	1564	37.6	1103	26.8	1178	28.7
5001 - 10000	801	19.3	809	19.7	729	17.7
10001 - 15000	313	7.5	412	10.0	435	10.6
15001 - 20000	309	7.4	336	8.2	310	7.5
20001 - 30000	392	9.4	427	10.4	454	11.0
30001 - 40000	154	3.7	234	5.7	189	4.6
40001 - 50000	92	2.2	172	4.2	236	5.7
50001 - 60000	21	0.5	65	1.6	60	1.5
60001 - 70000	91	2.2	89	2.2	124	3.0
Over 70000	85	2.0	186	4.5	191	4.6
Excess of Basic (Not Umbrella) Premiums						
None	3772	90.8	3737	90.9	3695	89.8
$1000 & Under	49	1.2	47	1.1	65	1.6
1001 - 5000	191	4.6	164	4.0	179	4.4
5001 - 10000	27	0.7	39	0.9	44	1.1
10001 - 15000	18	0.4	8	0.2	8	0.2
15001 - 20000	47	1.1	36	0.9	36	0.9
20001 - 30000	20	0.5	21	0.5	23	0.6
30001 - 40000	7	0.2	32	0.8	0	0.0
40001 - 50000	2	0.1	0	0.0	18	0.4
50001 - 60000	15	0.4	23	0.6	35	0.8
60001 - 70000	0	0.0	0	0.0	3	0.1
Over 70000	7	0.2	8	0.2	8	0.2
Malpractice Umbrella Premiums						
None	2035	49.0	1851	45.0	1604	39.0
$1000 & Under	579	13.9	414	10.1	568	13.8
1001 - 5000	1073	25.8	1212	29.5	1027	25.0
5001 - 10000	340	8.2	349	8.5	490	11.9
10001 - 15000	71	1.7	149	3.6	239	5.8
15001 - 20000	26	0.6	33	0.8	80	1.9
20001 - 30000	26	0.6	92	2.2	82	2.0
30001 - 40000	5	0.1	8	0.2	18	0.4
40001 - 50000	0	0.0	5	0.1	3	0.1
50001 - 60000	0	0.0	0	0.0	0	0.0
60001 - 70000	0	0.0	0	0.0	3	0.1

*Sum of components may not add to total due to rounding.

Bureau of Research Services, American Hospital Ass'n. LR:12/13/72

HOSPITAL PROFESSIONAL LIABILITY INSURANCE
BASIC COVERAGE LIMITS

	1970*		1971*		1972*	
	No.	Percent	No.	Percent	No.	Percent
Short-term Nongovernmental Hospitals	4155	100.0	4113	100.0	4113	100.0
Per Occurrence Limit						
100,000 and under	2138	51.5	1937	47.1	1772	43.1
100,001 - 300,000	907	21.8	973	23.7	1073	26.1
300,001 - 500,000	545	13.1	619	15.1	658	16.0
500,001 - 700,000	0	0.0	0	0.0	0	0.0
700,001 - 900,000	0	0.0	0	0.0	0	0.0
900,001 - 1,100,000	565	13.6	581	14.1	589	14.3
Over 1,100,000	0	0.0	3	0.1	21	0.5
Aggregate Limit						
100,000 and under	457	11.0	408	9.9	358	8.7
100,001 - 300,000	1827	44.0	1560	37.9	1503	36.6
300,001 - 500,000	735	17.7	906	22.0	910	22.1
500,001 - 700,000	53	1.3	102	2.5	138	3.4
700,001 - 900,000	39	0.9	38	0.9	56	1.4
900,001 - 1,100,000	962	23.1	992	24.1	999	24.3
Over 1,100,000	83	2.0	106	2.6	148	3.6

*Sum of components may not add to total due to rounding.

Bureau of Research Services, American Hospital Ass'n.
LR:12/13/72

HOSPITAL PROFESSIONAL LIABILITY INSURANCE
UMBRELLA COVERAGE LIMITS

	1970*		1971*		1972*	
	No.	Percent	No.	Percent	No.	Percent
Short-term Nongovernmental Hospitals	4155	100.0	4113	100.0	4113	100.0
Umbrella Coverage Limit						
No Umbrella Insurance	2035	49.0	1851	45.0	1604	39.0
Under 1,000,000	1104	26.6	984	23.9	1104	26.8
1,000,000 - 3,000,000	378	9.1	529	12.9	582	14.2
3,000,001 - 5,000,000	539	13.0	609	14.8	634	15.4
5,000,001 - 7,000,000	2	0.1	0	0.0	3	0.1
7,000,001 - 9,000,000	45	1.1	64	1.6	97	2.4
Over 9,000,000	51	1.2	76	1.8	88	2.1

*Sum of components may not add to total due to rounding.
Bureau of Research Services, American Hospital Ass'n.
LR:12/13/72

HOSPITAL PROFESSIONAL LIABILITY INSURANCE
EXCESS OF BASIC COVERAGE LIMITS

	1970*		1971*		1972*	
	No.	Percent	No.	Percent	No.	Percent
Short-term Nongovernmental Hospitals	4155	100.0	4113	100.0	4113	100.0
Per Occurrence Limit						
No Excess Insurance	3772	90.8	3737	90.9	3695	89.8
100,000 and under	68	1.6	69	1.7	54	1.3
100,001 - 300,000	92	2.2	103	2.5	118	2.9
300,001 - 500,000	72	1.7	56	1.4	74	1.8
500,001 - 700,000	0	0.0	0	0.0	0	0.0
700,001 - 900,000	42	1.0	42	1.0	42	1.0
900,001 - 1,100,000	5	0.1	5	0.1	5	0.1
Over 1,100,000	104	2.5	101	2.5	125	3.0
Aggregate Limit						
No Excess Insurance	3772	90.8	3737	90.9	3695	89.8
100,000 and under	0	0.0	0	0.0	0	0.0
100,001 - 300,000	117	2.8	113	2.8	96	2.3
300,001 - 500,000	25	0.6	23	0.6	41	1.0
500,001 - 700,000	18	0.4	21	0.5	21	0.5
700,001 - 900,000	24	0.6	38	0.9	38	0.9
900,001 - 1,100,000	70	1.7	38	0.9	38	0.9
Over 1,100,000	129	3.1	143	3.5	184	4.5

*Sum of components may not add to total due to rounding.

Bureau of Research Services, American Hospital Ass'n.
LR:12/13/72

NUMBER OF HOSPITAL PROFESSIONAL LIABILITY CLAIMS

	1967*		1968*		1969*		1970*		1971*	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Hospital–Sole Defendant										
None	3421	79.9	3239	77.1	3029	72.3	2899	69.8	2842	69.1
1	305	7.1	384	9.1	514	12.3	492	11.8	414	10.1
2	188	4.4	127	3.0	196	4.7	217	5.2	263	6.4
3	99	2.3	199	4.7	141	3.4	182	4.4	163	4.0
4	103	2.4	83	2.0	59	1.4	113	2.7	72	1.7
5	51	1.2	37	0.9	41	1.0	47	1.1	103	2.5
6 - 10	75	1.8	65	1.6	145	3.5	119	2.9	199	4.8
11 - 15	24	0.6	29	0.7	27	0.7	63	1.5	41	1.0
16 - 20	2	0.0	10	0.2	8	0.2	12	0.3	5	0.1
Over 20	13	0.3	24	0.6	25	0.6	12	0.3	10	0.3
Total	4282	100.0	4199	100.0	4187	100.0	4155	100.0	4113	100.0

	1967		1968		1969		1970		1971	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Hospital Co-Defendant										
None	3774	88.1	3564	84.9	3368	80.4	3165	76.2	3446	83.8
1	316	7.4	283	6.7	388	9.3	538	12.9	290	7.1
2	52	1.2	75	1.8	161	3.9	111	2.7	150	3.6
3	17	0.4	110	2.6	27	0.6	78	1.9	62	1.5
4	6	0.1	59	1.4	50	1.2	67	1.6	23	0.6
5	56	1.3	24	0.6	102	2.4	56	1.4	29	0.7
6 - 10	27	0.6	26	0.6	33	0.8	91	2.2	69	1.7
11 - 15	15	0.4	24	0.6	34	0.8	28	0.7	23	0.6
16 - 20	15	0.4	30	0.7	19	0.5	0	0.0	0	0.0
Over 20	2	0.0	4	0.1	6	0.1	22	0.5	21	0.5
Total	4282	100.0	4199	100.0	4187	100.0	4155	100.0	4113	100.0

*Sum of components may not add to total due to rounding.
Bureau of Research Services, American Hospital Ass'n.
LR:12/13/72

NUMBER OF HOSPITAL PROFESSIONAL LIABILITY CLAIMS
NUMBER OF CLAIMS PAID AND TOTAL DOLLARS PAID

	1967*		1968*		1969*		1970*		1971*	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Number of Claims Paid										
None	3308	77.3	3070	73.1	3035	72.5	3015	72.6	3188	77.5
1	398	9.3	549	13.1	493	11.8	562	13.5	465	11.3
2	226	5.3	255	6.1	281	6.7	281	6.8	195	4.7
3	176	4.1	130	3.1	142	3.4	91	2.2	167	4.1
4	41	1.0	26	0.6	52	1.2	48	1.2	27	0.6
5	48	1.1	24	0.6	59	1.4	59	1.4	27	0.6
6 - 10	62	1.5	112	2.7	109	2.6	66	1.6	37	0.9
11 - 15	20	0.5	15	0.4	7	0.2	28	0.7	3	0.1
16 - 20	2	0.0	14	0.3	7	0.2	3	0.1	3	0.1
Over 20	0	0.0	4	0.1	2	0.1	3	0.1	3	0.1
Total	4282	100.0	4199	100.0	4187	100.0	4155	100.0	4113	100.0

	1967		1968		1969		1970		1971	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Dollars Claims Paid										
None	3314	77.4	3061	72.9	3024	72.2	2972	71.5	3262	79.3
Under 1000	233	5.4	344	8.2	327	7.8	343	8.2	411	10.0
1001 - 2000	52	1.2	103	2.4	110	2.6	221	5.3	103	2.5
2001 - 3000	73	1.7	120	2.8	161	3.9	115	2.8	35	0.8
3001 - 4000	81	1.9	51	1.2	139	3.3	148	3.6	32	0.8
4001 - 5000	69	1.6	24	0.6	99	2.4	63	1.5	71	1.7
5001 - 10000	171	4.0	166	3.9	134	3.2	159	3.8	55	1.3
10001 - 20000	153	3.6	229	5.5	117	2.8	74	1.8	45	1.1
20001 - 30000	20	0.5	45	1.1	29	0.7	37	0.9	49	1.2
30001 - 40000	54	1.3	31	0.7	9	0.2	2	0.1	3	0.1
Over 40000	60	1.4	28	0.7	36	0.9	22	0.5	48	1.2
Total	4282	100.0	4199	100.0	4187	100.0	4155	100.0	4113	100.0

*Sum of components may not add to total due to rounding.

Bureau of Research Services, American Hospital Ass'n.
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NUMBER OF HOSPITAL PROFESSIONAL LIABILITY CLAIMS OUTSTANDING AND DOLLARS IN RESERVE FOR CLAIMS OUTSTANDING

	1967*		1968*		1969*		1970*		1971*	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Dollars in Reserve										
None	3919	91.5	3758	89.5	3352	80.1	3096	74.5	3032	73.7
Under 1000	53	1.2	36	0.8	82	2.0	54	1.3	88	2.1
1001 - 2000	50	1.2	19	0.4	91	2.2	46	1.1	56	1.4
2001 - 3000	20	0.5	100	2.4	97	2.3	145	3.5	62	1.5
3001 - 4000	2	0.0	0	0.0	4	0.1	38	0.9	67	1.6
4001 - 5000	24	0.6	59	1.4	62	1.5	78	1.9	191	4.6
5001 - 10000	63	1.5	17	0.4	188	4.5	191	4.6	173	4.2
10001 - 20000	65	1.5	65	1.6	101	2.4	211	5.1	160	3.9
20001 - 30000	6	0.1	59	1.4	43	1.0	124	3.0	82	2.0
30001 - 40000	6	0.1	38	0.9	54	1.3	32	0.8	36	0.9
Over 40000	73	1.7	50	1.2	113	2.7	140	3.4	166	4.0
Total	4282	100.0	4199	100.0	4187	100.0	4155	100.0	4113	100.0

	1967		1968		1969		1970		1971	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Number of Claims										
None	3934	91.9	3775	89.9	3391	81.0	3056	73.6	2941	71.5
1	246	5.7	166	4.0	442	10.6	528	12.7	482	11.7
2	61	1.4	104	2.5	146	3.5	171	4.1	336	8.2
3	12	0.3	73	1.7	93	2.2	182	4.4	84	2.0
4	20	0.5	6	0.2	28	0.7	87	2.1	55	1.3
5	2	0.0	25	0.6	54	1.3	29	0.7	139	3.4
6 - 10	4	0.1	36	0.9	24	0.6	84	2.0	55	1.3
11 - 15	0	0.0	11	0.3	4	0.1	12	0.3	11	0.3
16 - 20	2	0.0	2	0.1	2	0.1	0	0.0	3	0.1
Over 20	0	0.0	0	0.0	2	0.1	5	0.1	8	0.2
Total	4282	100.0	4199	100.0	4187	100.0	4155	100.0	4113	100.0

*Sum of components may not add to total due to rounding.

Bureau of Research Services, American Hospital Ass'n.
LR:12/13/72

NUMBER OF HOSPITAL PROFESSIONAL LIABILITY CLAIMS
SOLE AND CO-DEFENDANT CLAIMS

	1967*		1968*		1969*		1970*		1971*	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
None	3080	71.9	2783	66.3	2492	59.5	2270	54.6	2428	59.0
1	423	9.9	522	12.4	615	14.7	734	17.7	542	13.2
2	240	5.6	176	4.2	307	7.3	278	6.7	295	7.2
3	125	2.9	266	6.3	174	4.2	147	3.5	260	6.3
4	126	2.9	124	3.0	173	4.1	211	5.1	69	1.7
5	93	2.2	96	2.3	110	2.6	142	3.4	121	2.9
6 - 10	120	2.8	107	2.6	178	4.3	215	5.2	261	6.4
11 - 15	42	1.0	40	1.0	75	1.8	111	2.7	99	2.4
16 - 20	4	0.1	40	1.0	13	0.3	9	0.2	5	0.1
Over 20	29	0.7	45	1.1	50	1.2	38	0.9	33	0.8
Total	4282	100.0	4199	100.0	4187	100.0	4155	100.0	4113	100.0

*Sum of components may not add to total due to rounding.

Bureau of Research Services, American Hospital Ass'n. LR:12/13/72
LR:12/13/72

Please return to American Association, 840 North Lake Shore Drive,
Chicago, Ill. 60611 by October 31, 1972

HOSPITAL PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE QUESTIONNAIRE
(PANEL DATA, JUNE 1972)

HOSPITAL WORK COPY

1. Please describe your hospital's immunity status regarding hospital professional liability claims during the years 1967 to 1972.

	1967	1968	1969	1970	1971	1972
No immunity	____	____	____	____	____	____
Partial immunity	____	____	____	____	____	____
Complete immunity	____	____	____	____	____	____

2a. Does your hospital fully self-insure or partially self-insure against hospital professional liability claims?

Fully self-insure Yes ☐ No ☐
Partially self-insure Yes ☐ No ☐

2b. If YES, what was the dollar amount for self-insurance reserved by your hospital for hospital professional claims for 1970, 1971, and 1972?

1970	1971	1972
$________	$________	$________

3a. What were your hospital's annual premiums for professional liability coverage for the years 1970, 1971, and 1972? (If premiums are included in your Comprehensive General Insurance, please ESTIMATE the premium for professional liability. If premiums cover more than one year, pro-rate the premium cost per year. Include retrospective premium adjustments.)

	1970	1971	1972
Basic coverage premium	$________	$________	$________
Excess of basic (not umbrella)	$________	$________	$________
Malpractice umbrella (catastrophe) coverage limit	$________	$________	$________

3b. If your premiums increased or decreased more than 10 per cent from 1970 to 1971, or 1971 to 1972, please explain.

____
____
____

3c. Is your hospital professional liability coverage retrospectively rated? Yes ☐ No ☐

4. What were the limits of your hospital professional liability coverage for the years 1970, 1971, and 1972?

	1970		1971		1972	
	Per Occurrence	Annual Aggregate	Per Occurrence	Annual Aggregate	Per Occurrence	Annual Aggregate
Basic coverage limits	$	/$	$	/$	$	/$
Excess of basic (not umbrella)	$	/$	$	/$	$	/$
Malpractice umbrella (catastrophe) coverage limit	$		$		$	

5. How many hospital professional liability claims were filed against your hospital either singly or with other defendants for incidents that occurred during the years 1967 to 1971?

	Year Incident Occurred				
	1967	1968	1969	1970	1971
Hospital or sole defendant					
Hospital as co-defendant with other party(s)					

6. How many hospital professional liability claims were paid by your hospital or insurance companies for incidents that occurred during the years 1967 to 1971? (Include cost of investigation, defense, etc.)

	Year Incident Occurred				
	1967	1968	1969	1970	1971
Number of claims paid					
Total dollars paid	$	$	$	$	$

7. What are the total dollars your insurance carrier has in reserve now for hospital professional liability claims outstanding for each of the years 1967 to 1971?

	1967	1968	1969	1970	1971
Dollars in reserve for claims outstanding	$	$	$	$	$
Number of claims outstanding					

8. Has your hospital had difficulty securing the coverage desired for hospital professional liability? Yes ☐ No ☐

Comments: ____________________

Name (PLEASE PRINT) ____________________ Position ____________________

Telephone: Area Code __________ Number ____________________

A SURVEY OF PROFESSIONAL LIABILITY INCIDENCE IN MARYLAND

Claire P. Evans
Mary D. Hemelt, R.N., M.S., J.D.
James E. Olsson, Ph.D.

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I. Introduction

> Note: This study and report were carried out in accordance with the conditions outlined in the Annotated Code of the State of Maryland, 1957 Edition, Article 43, Section 149 C.

In September of 1970, the executive Committee of the Medical and Chirurgical Faculty of the State of Maryland (Med-Chi) authorized funds to conduct a survey to ascertain the extent of malpractice liability claims in Maryland. Med-Chi represents the majority of all physicians practicing in the state and has a membership of 3823 physicians.

Friends Medical Science Research Center, Inc., a private non-profit organization located in Catonsville was contracted by Med-Chi to carry out the survey.

The initial aims of the study, as outlined by Med-Chi, were manifold. In general, there was the desire to gain better insight into the causes of malpractice claims; to attempt to define trends in both claim types and physicians involved; and to determine the extent such claims increased over a ten-year period, specifically, from 1960 to 1970. Concomitant to the above, it was to be determined if there was justification for the continuing annual increases in premiums for liability insurance.

In addition, the following, often-stated hypotheses were to be tested for their validity.

- Foreign-trained physicians contribute a larger percentage of claims than those trained in the United States.
- Specific law-firms are involved in a large number of claims.
- There are certain high-risk specialties.
- Hospital emergency rooms are high-risk areas.
- Physicians involved in more than one incident pose a major problem.

As data collection and analysis proceeded, the authors encountered a number of difficulties, particularly in relation to the unavailability of certain data. It was realized at this point that some of the initial aims could not be fully pursued and that only tentative answers could be offered in some cases. However, the large majority of the stated hypotheses were tested and results, not anticipated in the original proposal, were found and included in this report. Some of the major difficulties which developed in the course of the project will be dealt with in the Discussion section of this report.

The significance of this study cannot only be measured by the specific results which are reported herein. It is especially important to realize that this survey is the first comprehensive effort to collect data related to malpractice

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claims as they involve physicians in Maryland. It is also unique because it concerns itself with medically confidential materials collected from various sources at different points in time. Furthermore, it demonstrates that data on critical items can be gathered, coded, and analyzed, and explains that the complexity of the subject does not preclude simplicity in system design.

The information gathered is based on files researched at The Medical and Chirurgical Faculty of Maryland, 1211 Cathedral Street, Baltimore, Md., 21201 and Anderson, Coe and King, Attorneys-at-Law, 800 Fidelity Bldg., Baltimore, Md. 21201. The Research Design of this study is by Research Data Systems.

II. Methodology

In order to collect the data necessary for this study, the records of the Med-Chi's program of professional liability were researched. This program began in mid-1960 following approval by the Med-Chi's House of Delegates and currently insures 3166 physicians or about 96% of those physicians practicing in the State of Maryland.

Several factors were considered; first, it was decided to utilize available information without involvement of either physicians or local insurance carriers, and second, the feasibility of obtaining privileged information on a broad basis with limited personnel involvement was tested.

It must be pointed out that the task of such data collection as written in this report may appear elementary, however, two major factors must be considered. Neither Med-Chi nor Friends had ever attempted a study of medical liability, and research of the literature did not provide any guidelines for this particular undertaking. The fact that sufficient material could be obtained from the amount of records searched and the many sources consulted must be considered a paramount accomplishment.[1]

A data collection instrument was designed and data collected between October 1970 and March 1971. As a result, 381 completed claims were used in this research effort. As a matter of interest it should be mentioned, however, that more than 500 claim files were read and evaluated. Those claims on which only fragmentary information could be extracted from the files were excluded from the study.

Before proceeding, it must be pointed out that certain assumptions have been made. All data collected have been extracted from various materials and the reliability or accuracy of such materials must be assumed. No actual checks for validity have been attempted, and, therefore, the results as reported here are based on data which is assumed to be factual to the best of the investigators' knowledge.

To insure non-duplication of claims the term companion case was applied to those arising from one incident against more than one physician and each case was used only once. Overall, the data collected provided information on 381 unduplicated cases, yielding the material for the present study and serving as the data base for comparisons and follow-up.

A. DATA COLLECTION FORM

The collection instrument was designed for easy coding. Data was collected by an administrative coordinator in collaboration with a nurse/attorney over a four-month period at two major locations. Completed forms were stored at the data processing center of Friends where preliminary coding and testing were carried out manually, simultaneous to the IBM 1130 computer runs.

The data collection form is composed of four parts as follows:

PART I - PHYSICIAN DATA

This was completed once on any physician. All information was obtained by searching available records of the local medical society and files provided by the American Medical Association.

PART II - PATIENT DATA

This was obtained either from the physician's claim report or from legal papers filed in court.

PART III - CLAIM DATA

Since this information provides the basis for the claim, this part had to be completed in detail in order to yield all information for rating procedure and severity. Physician's files, insurance records, and legal papers filed in court were utilized for this task.

PART IV - DISPOSITION OF CLAIM

As in Part III, most of this information could only be obtained through the insurance carrier.

B. CODES

The following codes were either developed for this study or adopted from existing codes utilized by the American Medical Association.

1. *Claim Number.* This unique number was assigned by the insurance carrier when a claim filed was opened, all information pertaining to a particular claim was referenced by this number.
2. *Name Codes.* Name codes for physicians, patients, and attorneys are 4-digit codes and were assigned on a unique basis and used for that particular individual regardless of the number of claims involved.
3. *Medical Specialties.* The standard codes provided by the American Medical Association were utilized.
4. *Procedure Codes.* Special codes were developed in accordance with those provided by the American Medical Association.[2]

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[1] A paper on the preliminary findings of this study was presented by Jonas R. Rappeport, M.D., Medical Services of the Supreme Bench in Baltimore, Maryland, assisted by Claire R. Evans at a meeting of the American Medical Association, Committee on Medicolegal Problems, held on March 17,1971, at the Americana Hotel, in New York City.

[2] B.L. Gordon (Ed.) *Current Procedural Terminology for naming-coding-reporting Diagnois and Treatment.* 2nd Edit., 1970. American Medical Association, Chicago, Illinois.

C. RATINGS

1. Ratings of Severity of Medical Effects. In any case where a patient has an unexpected effect from a medical procedure, the first concern is the severity of the effect on the patient whether or not a malpractice claim results from the procedure. Of course, once a claim has been made, both severity of effects and the question of malpractice are of major concern.

The investigators initially looked over brief descriptions of all claims and decided to use a seven-point rating scale on a small sample of the cases. This procedure resulted in a definition of each point in the scale (see Table 1 for Severity Scale Description) and helped the investigators to "calibrate" their ratings. Another sample of 40 cases was drawn from the total pool and were rated independently by four raters (the authors of this report, a psychiatrist, and a psychologist). Ratings were correlated for all raters using a Pearson Product-moment correlation technique. Correlation ratios indicated a high level of agreement among all raters with r's ranging from .88 to .97. Inspection of ratings indicated most were in exact agreement or had only one point difference. Apparently, severity of medical effects were rated with a high degree of reliability. With determination of high reliability, the authors used a joint method of rating the total sample. Each case was discussed and one rating agreed upon by both raters. Using this method, 357 cases were assigned severity scores and 24 cases were not rated due to insufficient information.

TABLE I

SCALE	DESCRIPTION
1	Result involved no temporary or permanent effect-general patient dissatisfaction
2	Very mild effect or moderate inconvenience caused
3	Mild to moderate temporary discomfort
4	Mild residual or severe temporary effect
5	Moderate severe residual/permanent damage
6	Severe residual/permanent damage
7	Death
0	Not rated because of insufficient information

These ratings yielded a mean severity score of 4.06 with a standard deviation of 2.02. The distribution of ratings along the seven point scale was as follows: 1=62; 2=37; 3=37; 4=46; 5=87; 6=32; and 7=56.

Males and females tended to have similar distribution of ratings except that females tended to have a higher number of cases with ratings of 1 and 7 and males a higher number of cases with ratings of 5.

Other results related to ratings of severity will be presented in the Findings section of this report.

III. Data Analysis

A tabular presentation of information collected and recorded on data forms is presented in Appendix I.[3] The major findings from these tables and other sources are summarized in the following pages.

Claim Information. There were a total 381 completed claim files which included 125 incidents and 256 suits.[4] In addition to the physician-defendents, co-defendents were named in 151 instances and involved hospitals, other physicians, manufacturers, etc. Twenty-five claims were excluded from analysis due to insufficient data (primarily patient information).

Med-Chi panels were provided for 90 claims.

Disposition Information. Tables 1 and 2 present the basic information regarding disposition of claims. As previously stated, the claim data was collected for a ten year period with the bulk of the data obtained from 1964 to 1967.[5]

According to the available data, 148 claims were still pending at the close of the data collection period and 233 claims had been closed with a known disposition.

Of the 233 claims on which dispositions were known, 137 were closed without monetary payment to the claimant. The main insurance carrier expended approximately $15,000.00 to process and close these claims. It is important to note that claims settled without payment comprised one half of the total number of cases closed within the ten-year period researched.

Eighty-one claims were settled out of court for a total amount of $721,284.64. As presented in Table 2 the settlements ranged from $20.00 to $82,000.00. The median amount was $1,200.00. In addition, $74,028.50 was spent to process the above claims.

Of 30 cases tried in court 23 decisions were in favor of the defendent-physician and 7 in favor of the claimants. The total amount paid to the claimants was $753,052.98. The median amount was $88,000.00 and the range was from $25,000.00 to $298,000.00. In addition to these awards, $92,953.19 was paid in court cost and other related expenses for the total cases tried in court.

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[3] Appendix I of this study has not been reproduced in this volume.

[4] An incident is a claim against a physician where no legal counsel has been obtained as opposed to the actual law suit where a lawyer has entered the case or suit is filed in court.

[5] It must be pointed out that due to the lesser number of physicians covered by the main insurance carrier during the earlier years and the delay in filing claims during the later years, a trend analysis of results over the 10-year period would be subject to misinterpretation and was not done.

TABLE 2
INFORMATION ON CLAIM DISPOSITION AS OF JUNE, 1971

Year of Occurrence	Total N	Still Pending	Closed Claims						Other Expenses	Grand Total
			No Payment To Claimant	No Info Available	Settled Out of Court N	$	Court N	Award $		
1960	13	5	3	1	4	12,166.67	-	-0-	-0-	12,166.67
1961	30	5	8	4	13	49,988.90	-	-0-	8,763.18	58,752.08
1962	39	9	19	-	11	87,600.00	-	-0-	10,659.28	98,259.28
1963	35	9	16	-	8	19,115.60	2	350,750.00	1,445.46	371,311.06
1964	59	18	29	1	11	83,824.52	1	25,000.00	80,454.77	189,279.29
1965	59	19	20	1	16	225,353.95	3	345,500.00	53,577.69	624,431.64
1966	42	15	17	1	8	169,750.00	1	31,802.98	17,860.47	219,413.45
1967	59	35	18	-	6	11,735.00	-	-0-	4,436.31	16,171.31
1968	25	16	6	-	3	61,750.00	-	-0-	4,769.25	66,519.25
1969	14	12	2	-	-	-0-	-	-0-	-0-	-0-
1970	6	5	1	-	-	-0-	-	-0-	-0-	-0-
Totals:	381	148	137	8	81	721,284.64	7	753,052.98	181,966.41	1,656,304.03
Percent:		40%	36%	2%	21%		2%			

TABLE 3
DISTRIBUTION OF OUT-OF-COURT SETTLEMENTS

$ Amounts	Number Claims	%
Under 99.00	13	10.7
100.00 to 499.00	24	19.6
500.00 to 999.00	21	12.2
1,000.00 to 4,999.00	34	27.9
5,000.00 to 9,999.00	11	9.1
10,000.00 to 49,999.00	14	11.4
50,000.00 to 99,999.00	5	4.1
Total:	122	

Median Amount = $1,200.00
Range = $20.00 --- $82,624.01

Physician Information. The 381 completed claim files involved 322 physicians. Forty-six physicians had more than one claim during the ten-year period analyzed. (See Hypotheses for further data on this group). The majority of physicians (57%) practiced in the urban area, were born between 1911 and 1930 (70%), and had been in practice an average of fourteen years. The average year of physicians' licensure in Maryland was 1950. Of the claims researched, 299 (93%) of the physicians carried St. Paul's insurance.

Concerning the physicians' educational background it was noted that the mean year of graduation was 1946; most (80%) attended colleges or universities in the United States, which was followed by residency training by 85% of the physicians. Only 27% had additional specialty training which leads to the assumption that most (71%) stayed within the medical discipline chosen during residency. Most (57%) of the physicians were in solo practice with partnerships recorded as 19%.

There were 158 (49%) physicians who were specialty board certified and 153 (48%) who had not taken board examinations. Tests of significance did not reveal any discernible differences between these two groups in terms of number of claims.

Some of the above physicians' characteristics have been compared with the overall membership of the Medical and Chirurgical Faculty of Maryland. These comparisons can be found elsewhere in this section.

Patient Information. There were 177 male and 204 female claimants. Urban (53%) and suburban (34%) patients constituted the majority of the claim population. Forty-three percent of the procedures performed, which led to the claim, were listed as elective, with routine care second at 29%, and emergency care last with 28%. Interestingly, 125 (33%) of the claimants had been regular patients of the physician before claim was made. On the other hand, 183 (48%) of the patients had never been seen by the physician involved prior to the claim incident. However, this 48% is composed primarily of referrals to specialists; visits to the emergency room area, and claims against anesthesiologists attending during surgical procedures. Along the same vein, 247 (65%) of the claimants, had been under the physicians' care less than one year.

Several special tables were prepared to highlight certain information. In Table 4, incident and suit data are presented according to the location of the physician. This table shows that the majority (57%) of all claims originated in Baltimore City (Urban location), and the remainder in Suburban, Rural or Out of State locations. This finding should be qualified, however, with the fact that all cases originating in the suburban counties of Washington, D.C. may not have been reported to Med-Chi. Table 3 also indicates the distribution and average ratings of severity by location of physician. In the last two columns of Table 3 a comparison is presented between the claim group and Med-Chi membership according to physician location. Apparently, the urban physicians are not only involved in the absolute majority of malpractice cases, but also have a proportionately greater percentage of claims when compared to their representation within Med-Chi membership (Chi Square Test statistical significance = .05).

Table 4 presents incident and suit data according to physician age grouping. A major, consistent finding which is revealed in this table indicates that the 35 - 44 age group has the highest malpractice risk according to all measures. That is, this group has the highest absolute number of malpractice claims of any other age group, the highest average severity rating, and a proportionately greater percentage of physicians with claims when compared to its representation within Med-Chi membership. In contrast, the 25 - 34 age group has a proportionately smaller percentage of physicians with claims (Chi-square statistical significance = .01). An explanation of this finding may involve a number of factors. However, all that may be pointed to with any certainty in this report is the estimated larger number of patients being seen by the 35 - 44 age group compared to younger or older groups.

Table 6 presents incident and suit data according to physician specialty. In terms of absolute number of claims, four specialty groups stand out: Anesthesiology, General Practice, General Surgery, and Obstetrics/Gynecology. When these groups are compared with their representation in Med-Chi membership, each group except General Practice, has a proportionately greater percentage of physicians having claims than would be expected. (See Table 5 for statistical significance.) While other specialty groups can be evaluated in terms of these data, caution should be exercised due to the low number of cases involved.

In terms of average severity ratings, most groups are not significantly different from the overall average. However, certain specialties do have significantly higher or lower averages. Anesthesiology is low with a 3.1 average (t-test statistical significance = .01). This reflects the high incidence of broken teeth and only a few deaths. Thoracic

TABLE 4
INCIDENT AND SUIT DATA ACCORDING TO PHYSICIAN LOCATION

Physician Location	Number Of Incidents And Suits	Per Cent	Not Rated	Distribution of Severity			Average Severity Rating	Claim Group %	Med-Chi Members %
				1+2	3-5	6+7			
Urban	218	57.2	14	56	100	48	4.0	54.4	46.1
Suburban	88	23.1	7	21	32	28	4.3	28.5	34.4
Rural	67	17.6	3	19	33	12	3.8	14.9	17.6
Out of State	8	2.1	-	3	5	-	3.5	2.2	1.9
Total	381		24	99	170	88			

TABLE 5
INCIDENT AND SUIT DATA ACCORDING TO PHYSICIAN AGE GROUPING

Physician Age	Total Number Of Incidents And Suits	Per Cent	Not Rated	Distribution of Severity			Average Severity Rating	Claim Group (per cent)	Med-Chi Members (per cent)
				1+2	3-5	6+7			
24 or Younger	3	.7	3	-	-	-	-	0.3	0.9
25 - 34	40	10.4	2	12	17	9	4.0	11.5	22.9
35 - 44	157	41.2	11	36	67	43	4.3	43.8	35.0
45 - 54	98	24.9	4	23	46	25	3.1	26.1	22.9
55 - 64	55	14.5	3	18	30	4	3.7	10.9	12.2
65 or Older	13	4.1	1	6	2	4	3.7	3.4	5.2
	N/A 15	4.2		4	8	3	4.0	4.0	1.0
	Total 381		24	99	170	88			

surgery has an average rating of 5.5 (t-test statistical significance = .05), reflecting primarily the high incidence of deaths of patients. The rating of other specialties could not be evaluated reliably due to the low number of cases involved.

Table 7 presents incident and suit data according to place of occurrence and sex of patient. Overall, there are more female patients involved in malpractice claims than male patients. There are also differences between sexes in terms of claims by place of occurrence. Females have claims originating more often in hospitals whereas males have more claims originating in the emergency rooms (Chi-square statistical significance = .02). Regarding place of occurrence only, the greatest number of claims originated from in-patient hospital areas (206); then at the physicians' office (110); followed by the hospital emergency room (55). Since no comparative figures are available concerning the total number of patients being treated in these locations, no definitive conclusions can be drawn regarding the level of malpractice risk according to place of occurrence.

Review of Hypotheses

As stated in the purpose of the study, some often-used hypotheses were tested for their validity or rejection. The following conclusions were drawn from the available data.

Foreign-trained physicians in Practice Contribute a Larger Percentage of Claims than those Trained in the United States.

Of the 322 physicians having a claim against them, 48 (15%) were trained at foreign, non-English speaking medical schools. The Med-Chi membership lists 19% physicians as being trained at foreign, non-English speaking medical schools. Physicians presently in internship or residency training have not been included in the above statistics.

Based on the above information this hypothesis appears to be rejected.

Specific Law Firms are Involved in a Large Number of Claims.

A total of 171 attorneys handled claims over the ten-year period. Based on the available data, 149 (87%) of these attorneys handled one claim each. There was only one firm handling 8 claims during this total time; one firm handling 5 claims, and one firm handling 4 claims. No one firm handled any appreciable number of claims during this ten-year period to indicate that a specific lawyer or law firm was involved in a large number of claims. This would appear to reject the stated hypothesis.

There are Certain High-Risk Specialties.

When specialty groups were compared to their representation in Med-Chi certain specialties had a proportionately greater percentage of physicians with claims than would be expected. This finding supports the stated hypothesis.

Hospital Emergency Rooms are High-Risk Areas.

It was found that hospital emergency rooms rated third in the progressive sequence of numbers of claims by places of occurrence. There were 55 (14%) claims which originated in emergency rooms. Higher risk areas, in terms of absolute number of incidents, were found to be the in-patient hospital areas and the physician's office. Based

TABLE 6
INCIDENT AND SUIT DATA ACCORDING TO SPECIALTY GROUP

Specialty	Number of Incidents and Suits	Per Cent	Distribution of Severity			Average Severity Rating	Physicians	
			1+2	3-5	6+7		Claim Group	Members Med-Chi
09 Anesthesiology	36	9.8	19	12	4	3.1	** 9.0	4.1
15 Cardiovascular	1	.2	-	1	-	5.0	0.3	0.8
21 Dermatology	3	.7	1	2	-	3.6	0.6	1.3
27 General Practice	64	16.8	21	18	16	3.9	16.1	19.0
30 General Surgery	86	22.5	18	43	18	4.1	** 21.7	10.2
33 Internal Medicine	26	6.8	8	13	3	3.5	** 7.5	15.8
36 Neurosurgery	5	1.3	-	2	3	5.4	1.6	0.8
42 Ob/Gyn	68	17.8	18	28	20	4.1	** 16.5	9.3
48 Ophthalmology	2	.5	-	1	1	5.5	0.6	3.4
51 Orthopedic Surgery	15	3.9	4	8	3	3.8	* 4.7	2.4
54 Otolaryngology	9	2.3	2	7	-	3.6	2.8	2.2
57 Pathology	4	1.1	1	2	1	4.6	0.9	2.3
60 Pediatrics	11	2.8	1	7	3	4.8	* 3.4	6.6
63 Pediatric Allergy	1	.2	-	1	-	5.0	-	0.1
69 Phys. Med. & Rehab.	2	.5	-	2	-	3.5	0.3	0.4
72 Plastic Surgery	4	1.1	1	1	2	4.7	1.2	0.6
81 Psychiatry	6	1.6	2	1	3	4.6	1.6	9.4
87 Pulmonary Disease	1	.2	-	1	-	4.0	0.3	0.3
78 Colon & Rectal Sur.	1	.2	-	-	1	6.0	0.3	0.1
90 Radiology	8	2.0	-	7	-	4.4	2.5	3.1
91 Therap. Radiology	1	.2	-	1	-	4.0	0.3	0.1
93 Thoracic Surgery	9	2.2	-	5	3	5.5	* 2.2	0.8
96 Urology	8	2.0	2	2	4	4.8	2.2	1.9
99 Other	1	.2	-	1	-	3.0	0.3	0.2
N/A	9	2.3	1	4	3	4.8	2.8	1.4
				Grand Average		4.1		
Total	381		99	170	88	357+		

+Excludes 24 cases not ratable for severity
*Chi-square test statistical significance = .05
**Chi-square test statistical significance = .01

TABLE 7
INCIDENT AND SUIT DATA ACCORDING TO PLACE OF OCCURRENCE

Place of Occurrence	Sex of Patient				Total		Average Severity Rating	Distribution of Severity			Not Rated
	Male		Female								
	N	%	N	%	N	%		1+2	3-5	6+7	
In-Patient, Hospital	85	23.1	121	31.7	206	54.2	4.1	56	91	49	10
Out-Patient, Hospital	1	0.3	2	0.6	3	.7	3.6	1	2	-	-
Hospital Emergency Room	35	9.2	20	5.2	55	14.4	4.6	6	31	17	1
Physician's Office	51	12.4	59	15.5	110	28.8	3.5	34	44	20	12
Patient's Home	4	1.1	1	0.3	5	1.4	4.8	1	2	2	-
Other	1	0.3	1	0.3	2	.5	1.0	1	-	-	1
Total	177	46.4	204	53.6	381	100.0		99	170	88	24

on the above information, this would appear to reject the stated hypothesis.

Physicians Involved in More Than One Incident Pose a Major Problem.

Of the 322 physicians involved in incidents over the ten-year period researched, 46 (14%) had multiple claims. Of those, 36 had two claims each; 7 had three claims each; and 3 had four claims each. These 105 multiple claims constituted 28% of the total number evaluated for this study. The average severity ratings as related to these multiple claims were found to be 4.0. In order to test this hypothesis it would be necessary to have more data on several variables such as number of patients seen by each physician, number of visits by each patient, the specifics of each claim, etc. Because this data was not available for this study, no conclusion relating to this particular hypothesis was made.

IV. Discussion, Summary, and Conclusion

An overview of the findings suggests the following conclusions: The malpractice situation in Maryland does not appear as serious as reported in other areas of the country. We cannot base this conclusion upon direct comparisons with findings in other states, but the results of this study have not revealed large numbers of claims or exceptionally high settlements. Briefly, 50% of all closed claims resulted in no payment, and of those that had payments, amounts were generally low ($1,000 to $5,000.)

Settlements awarded by courts, as could be expected, did result in higher payments than out of court settlements. However, the majority of court cases were decided in favor of the physician-defendent, and extremely high court awards (over $100,000) numbered only three for this ten-year period.

Med-Chi panels were held in 90 of 381 claim cases. Perhaps some attempt should be made to draw conclusions regarding the need for more panels from these figures, but such conclusions are beyond the scope of these authors on the basis of the available data.

Little information was available regarding patient-plaintiffs other than sex. Even age of the patient was difficult to determine reliably. Future surveys could collect more relevant information descriptive of patients involved in malpractice claims.

Elective procedures involved the highest number of claims with routine and emergency care somewhat lower indicating that surgery is the highest risk procedure. The higher occurrence of claims originating from in-patient hospitals points to the same conclusion.

Several physician variables appear related to the increased likelihood of malpractice claims in this survey: 1) age between 35 and 44; 2) specialty in anesthesiology, general surgery, obstetrics/gynecology, and thoracic surgery; and 3) practice in an urban area (although this factor may be distorted by missing data from suburban physicians). Other hypothesized relationships such as foreign trained physicians having a potentially greater number of claims, were not substantiated.

Physicians involved in more than one claim do not appear to have contributed disproportionately to the malpractice problem, although such a conclusion is primarily based upon a subjective evaluation of findings and not upon statistical analysis. A larger sample of total cases and more detailed information regarding physicians are considered to be necessary for a definitive conclusion.

As noted in other sections of this report, the authors encountered a number of difficulties in obtaining the necessary data. A primary problem was that information was not located in any one central file, and had to be obtained from a number of sources including the American Medical Association records. Also, in any one file, data were not organized in a consistent fashion necessitating much additional search of the files. In all areas, patient, physician, claim, and disposition, there was a number of instances of missing and incomplete data which could have been avoided if a consistent record keeping system initially had been utilized.

In conclusion, the findings of this survey have touched upon a number of aspects of the malpractice situation in the State of Maryland. While some of these findings can likely be generalized, many of the findings are specific to the situation found in Maryland during the years covered by this study. Furthermore, we must reiterate that incomplete data in some instances could possibly have influenced our findings. This is particularly true in regard to those settled cases where money amounts (if any) are unknown. The basic fact to keep in mind regarding this survey is that it was a retrospective attempt to answer questions, a method having many drawbacks, as we have noted.

COMMENTS ON A SURVEY OF PROFESSIONAL LIABILITY INCIDENCE IN MARYLAND

William R. Pabst, Jr., Ph.D.

Summary

This excellent report on the phenomena of medical malpractice in Maryland over the period 1960 to 1970 presents descriptive data from 381 claims taken from the records of the Medical and Chirurgical Faculty of Maryland's program of professional liability. Med-Chi now insures, through St. Paul Fire and Marine Insurance Company, 3,166 physicians and has a membership of 3,823 physicians. Among the conclusions reached, one of the most important is "the malpractice situation in Maryland does not appear as serious as reported in other areas of the country."

The study suggests that the incidence of malpractice claims is related to the physician's specialty, his age, and his location. Several hypotheses concerning malpractice were established and tested, with the findings that foreign-trained physicians contribute no more than their share of malpractice; that hospital emergency rooms do not appear to be high risk areas; and that several high risk specialties exist. Our analysis of the data presented reveals that individual physicians are prone to malpractice suits.

Copious tables are given. The authors stress that this study is an exploratory one, that the data sources were not unified or organized, and that the results may be incomplete. The authors wished to establish trends over the period of study, but felt that they could not do so because of inadequate data. They also wished to make comparisons with other studies. They provide recommendations for future study, most of which deal with the tabulation, storage, and treatment of collected data.

At the risk of venturing where the authors feared to tread, we make some calculation of rates of occurrences, ratios of settlements, statistical analyses, and other comments in the following notes with the hope that these may be useful in the ongoing studies. These comments will discuss:

(1) Rates of malpractice claims per 100 physicians;
(2) Settlement amounts;
(3) Ratios of settlement for plaintiff and defendant;
(4) Malpractice proneness of physicians;
(5) Lawyers or law firms handling multiple claims;
(6) Male versus female propensity to malpractice;
(7) Ratings of severity; and
(8) High risk specialities.

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This report was originally prepared as a background paper for the Secretary's Commission on Medical Malpractice, U.S. Department of Health, Education, and Welfare, Report No.SCMM-WP-MS.

1. Rates of Malpractice Claims per 100 Physicians

The 381 malpractice claims studied consisted of 125 incidents and 256 suits, an incident being a claim against a physician where no legal counsel has been obtained, and a suit being a claim which is filed in court or a lawyer has entered. Measured against the 3,166 Med-Chi physicians insured (or the 3,823 members of Med-Chi), the estimated rate of malpractice claims is equal to or less than 12 claims per 100 physicians insured, or ten claims per member physician for the decade.

This estimated rate may be low because the number of insured physicians may have increased over the decade studied. If the number of physicians insured increased at about the national rate (of 25%) over the decade, the rate would advance from 12 to nearly 14 average number of claims per 100 physicians insured.

This estimated rate may also be too low because 25 claims were excluded from analysis due to insufficient data (primarily patient). With these included, the rate would be close to 13 per 100 insured physicians at end of period, and close to 15 per 100 physicians averaged over the decade. The report also indicates that 151 instances involving hospital, manufacturer, physician, or other, co-defendants were also not included (the number of co-physician suits not being known).

The "Physicians' Attitude Survey", reported in *Medical Opinion*, December 1971 (pages 43-47), indicated that among the 967 physicians volunteering responses, 17 in each 100 had been sued for malpractice and another 27 had been threatened during their careers. The rate of malpractice suits, 17 per 100 physicians during their careers, does not seem to be far out of line with the highest rate of claims disclosed in the Maryland study, 15 per 100 physicians per decade. This correspondence weakens, however, if threats are included in the *Medical Opinion* score, or if incidents are separated from suits in the Maryland data. One can only conclude that the Maryland data appear to show that medical malpractice claim is less frequent than the *Medical Opinion* report might show. One might even suspect that the *Medical Opinion* rate of malpractice suit or threat is somewhat biased on the high side by the tendency of those physicians personally involved in malpractice events to report their opinions.

The observed Maryland rates seem to be far lower than the rates of claims incidence given in the Ross-Loos study.[1] The number of claims in that study was found to be 14.17 claims per 100 physicians in 1970. These figures, giving rise to the expression of "the usual claim rate of 15 claims per 100 physicians per year", are in sharp contrast to the Maryland data in which the highest of the claim rates that seem to emerge is 15 per 100 physicians per decade, or 1.5 per 100 physicians per year. All things considered, one must judge that the Maryland rate of malpractice claims is very low indeed.

2. Settlement Amounts

Table 1 of the Maryland report shows that the 81 claims settled out of court involved $721,000, the seven court cases involved $753,000; and expenses amounted to $182,000: a total of $1,656,304.03 loss to the insurer. This averages $525.00 per insured physician for the decade. Allowing for the 25% increase in physicians over the decade, this might amount to as much as $65.00 per year per insured physician.

However, the report shows that of the 381 claims examined for the study, 233 have been settled and 148 are pending. If the number of claims pending has increased over the decade, these might be reflected in the decade costs per physician. However, cases pending might be counted in the next years or in the next decade as the study progresses.

The amount of malpractice settlement and expenses, amounting to less than $100.00 on a per year per physician basis (approximately $8.00 per month or $0.50 per day), does not seem to be a major expense for most physicians.

3. Ratios of Settlement for Plaintiffs and Defendents

Of the 381 claims analyzed, 148 were found pending and eight provided no information on settlements. For the 225 claims remaining, a table showing the number settled in favor of the plaintiff and the defendent can be constructed as shown below. Some 36 of the claims involved Med-Chi panels (whether these were settled in or out of court is not indicated). The decision ratios are then calculated:

Claims	Settled in Court	Settled out of Court	Total	Claims Involving Med-Chi Panels
For plaintiff	7	81	88	7*
For defendant	23	114	137	29**
Total	30	195	225	36
Decision ratio***	0.23	0.42	0.39	0.19

*Nondefensible
**Defensible
***The decision ratio is defined as the number of plaintiff/plaintiff plus defendant decisions; i.e., plaintiff wins as a proportion ot total decisions.

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[1] See "Alternatives to Litigation, I: Technical Analysis", *supra*, pp. 214ff.

Decision ratios, which are related in a general way to the degree of justice provided by the settlement process, were found to be generally from 0.27 to 0.34 in the medical-legal panels' settlements over a period of time, and to be 0.34 for all defendents in jury verdicts.[2]

The court-settled ratio indicated for Maryland above, in contrast to the out-of-court settlement ratio, may show the tendency of the carrier to settle most cases out of court where he does not have advantage. The ratio involving Med-Chi panels does appear to favor defendent, but it may be that the cases are screened before they are brought to panels, like those settled in court. One would therefore like to study the characteristics of court-settled and the panel-involved claims to determine why the ratios are so different from the others.

4. Physicians Involved in More Than One Malpractice Event (Incident or Suit)

The report states, "of the 322 physicians involved in incidents over the ten-year period researched, 46 (14%) had multiple claims. Of those, 36 had two claims each, 7 had three claims each, and 3 had four claims each." The report also indicates that Med-Chi's program insures 3,166 physicians. From these given data, the following table and analysis can be constructed along the line of R. A. Fisher's celebrated example.[3] This table compares the observed distribution of the 3,166 physicians (shown in column 2) by frequency of claim with the expected distribution (shown in column 4). The expected distribution is what might be expected from selecting the 381 numbers (representing claims) from a bowl containing the 3,166 numbers (representing physicians), replacing the number, and mixing after each selection. Repeated drawing of the 381 numbers will show some variation in the number of pairs, triples, etc., arising from the well known laws of chance.

Frequency of Claim	Observed Number of Physicians	Number of Claims	Poisson Expected Percent*	Expected Number of Physicians	Chi-Square Statistic
0	2,844	0	88.69	2,808	0.46
1	276	276	10.64	337	7.72
2	36	72	0.64	20	29.76
3	7	21	0.25	1	
4	3	12	0.00	0	
Total	3,166	381	100.00	3,166	50.74**

* Based on the observed rate = 381/3166 = 0.12 or 12 per 100 physicians

** Very significant for XP$_{0.001}$, 2 = 13.82

The number of physicians involved in only one claim is expected to be 337, much greater than the number observed to have one claim (276). The number expected to have more than one claim is only 21, in sharp contrast to the 46 observed. The chi-square test of significance shows that this difference between expected and observed, especially the difference between 21 and 46, is very significant; that is, this big difference might not be expected by chance more frequently than once in a million times.

The conclusion is thus a strong one that malpractice claim-proneness among physicians does exist. The data do not explain why it exists, however. Further investigation of the 105 claims in which the 46 multiple-claim physicians were involved might shed some light on the nature and possible cause of proneness. The proneness could be related to speciality, age, personality, training, nature of practice, or other factors. If proneness is found to be associated with specialty, further exploration using the techniques above might be made to determine whether individual doctors within a specialty were also malpractice-prone.

This conclusion does not disagree with the general ones reached in the report. It simply uses the available statistical tools to make more precise use of the admittedly limited data.

5. Lawyers and Law Firms Handling More Than One Claim

The report rejects the hypothesis that "specific law firms are involved in a large number of cases". This eonclusion can be made more specific by an examination of the basic data on 204 cases involving lawyers (out of the 256 claims) as shown in the following table:

Frequency of Cases per Lawyer	Observed Number of Lawyers	Number of Cases
1	149	149
2	19	38
3	0	0
4	1	4
5	1	5
8	1	8
Total	171	204

The American Bar Association reports that there were 4,624 lawyers in private practice in Maryland in 1970. (Statistical Abstract p. 154) With one malpractice claim to every 20 lawyers, one would expect by chance alone that no more than five lawyers would have more than one case and that 194 would have just one case. The fact that there were 19 lawyers with two cases and three others with multiple numbers does suggest that some few lawyers do seek out such cases or are sought out for handling them. Some 9% of the cases were handled by the multi-case lawyers and nearly 19% by those handling two cases. Thus there is evidence that some lawyers, at least the three multiple ones, do have affinity for malpractice claims. This questions thus whether the report hypothesis is properly rejected. Whether there is a difference in the type of claim handled by the single versus multiple-case lawyer in terms of injury severity or settlement amount might add much to the study.

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[2] *Ibid.*

[3] R.A. Fisher, *Statistical Methods for Research Work*, 8th. ed., London, 1941.

6. Male Versus Female

Some interaction appears to be involved between the sex of the patient and the category of procedure involved, as shown in the Maryland data. The pertinent data are:

Procedure	Number of Claims		
	Male	Female	Total
Elective	55	99	154
Emergency	62	45	107
Routine	50	60	110
Total	177	204	381

The large number of claims (99) arising from elective-female procedures may be associated with the high incidence of claims in the obstetrics/gynecology specialty. The relatively high number associated with male-emergency procedure (62) suggests a relationship to accidents.

7. Ratings of Severity

The seven-step severity scale[4] used has some shortcomings in translating descriptive terms into numerical sequence. Notwithstanding the tests of concordance among the different scorers made, the question has not been faced whether the numbers are either measure or rank, e.g., as a measure, does four equal twice the severity of two; or, as a rank, does four indicate merely some greater severity than three or two? The data from the 381 claims show this distribution of severity.

Score	Frequency
1	--62
2	-------------------------------------37
3	-------------------------------------37
4	---46
5	--87
6	--------------------------32
7	---56

The irregular shape of this distribution may arise in part from the lack of distinction among the categories 1, 2, and 3, the verbal description of 3 seeming to imply in some cases a less serious consequence than 1. Similarly the distinction between 5 and 6 is also difficult as reflected by the small number in category 6. The result is that the major categories are 1, 4, 5, and 7. The averages of severity are thus affected by these half missing categories, and thus are difficult to describe in numerical meaning. Moreover, in combining these, category 3 belongs with 1 and 2; and 6 with 5 instead of 7. The point is that considerable improvement could be made in the ordering of severity, perhaps by changing the number of intervals or by making the definitions accord more closely with the numerical steps.

is that considerable improvement could be made in the ordering of severity, perhaps by changing the number of intervals or by making the definitions accord more closely with the numerical steps.

In any event, the average severity ratings do not add much to the clarity of the data, except perhaps in the case of the less severe ratings of the anesthesiology claims.

8. High Risk Specialties

The information provided in Table 5 makes possible the following abbreviated table of the four high risk specialties:

Specialty	Number of Claims	Percent of Claims	Percent of Med-Chi Members	Ratio % Claims/ % Members
Anesthesiology	36	9.8	4.1	2.39
General surgery	86	22.5	10.2	2.21
Ob/Gyn	68	17.8	9.3	1.91
Thoracic surgery	9	2.2	0.8	2.75
Subtotal, high risk specialty	199	52.3	24.4	2.14
All other	182	47.7	75.6	0.63
Total	381	100.0	100.0	1.0

Slightly more than half the total claims are associated with the four high risk specialties, but less than a quarter of the membership. The ratios show little difference in the rate of claims among the four high risk specialties, and that the high risk rate of claim is just about 3-1/2 times that for all other specialties.

9. Conclusion

While these notes bear out the major conclusions of the Maryland study, they draw out some of the implications that may have been somewhat embedded in the extensive tables. The major differences are primarily in the use of more positive statistical tests that malpractice proneness does exist among the physicians having more than one claim during the period, and in the influence of attorneys involved in more than one claim. Both these subjects require further study. The information developed on the rates of malpractice claims per physician per year, and the amounts involved in settlements per physician per year, certainly substantiate the conclusion that the malpractice situation in Maryland during this period does not appear serious.

To all those concerned with medicine, this finding will be very good news. Those concerned might be remiss, however, if they did not push this information to inquire into the causes of this favorable showing—is the standard of practice better in Maryland than in other places, are the lawyers less aggressive, does Maryland retain the physician's personal touch, are patients less aware of their rights, has defensive medicine been used extensively, or are the data simply inadequate for the purposes? Perhaps the extended studies of the Maryland data planned for the future will enable the testing of these other hypothesis on a comparative basis.

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[4] See "A Survey of Professional Liability Incidence in Maryland," *Supra*, pp. 623ff.

PROFESSIONAL LIABILITY PROBLEMS AMONG ARCHITECTS, ENGINEERS, LAWYERS, AND ACCOUNTANTS

Beatrix W. Shear

Summary

In summary it might be said that the professions of architecture, engineering, law, and accounting, as well as the medical profession, are all experiencing the same trends with regard to professional liability in substantial, although somewhat varying degrees. That is, they have each experienced increases in the volume of malpractice claims and suits; higher awards and settlements; rising insurance costs; variations in rates according to geographical location and professional specialty; a dearth of carriers willing to write acceptable coverage; a felt need for group-affiliated insurance programs; and increased concern for developing "loss prevention" programs as important tools in reducing claims and suits.

For now, it appears that physicians and surgeons are getting the worst of the malpractice claims and suits avalanche. They are, however, not alone in their plight.

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Introduction

Many physicians and hospital administrators have expressed the belief that malpractice activity against the medical profession has been unjustifiably excessive compared to malpractice activity against other professions. In order to provide a basis for an inter-professional comparison of malpractice trends and to illuminate some of the factors that influence professional liability trends in general, we have investigated the nature of the malpractice problems and trends in malpractice insurance rates in the professions of architecture, engineering, law, and accounting. The following report is a summary of our findings.

Architects and Engineers

Architects and engineers involved in construction, like members of the medical community, have experienced increases in the volume and size of professional liability claims and suits in recent years. Evidence of these increases is provided by the history of the professional liability insurance program sponsored by the American Institute of Architects and the National Society of Professional Engineers. The program provides coverage for an estimated 90% to 95% of the nation's private practice architects and engineers involved in construction who purchase professional liability coverage and recently was expanded to provide coverage for soils engineers as well.[1] Its Administrator reports that the frequency of

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[1] Association membership is not required for participation in the AIA-NSPE insurance program.

This Report was originally prepared as a background paper for the Secretary's Commission on Medical Malpractice, U.S. Department of Health, Education, and Welfare. Report No. SCMM-BS-CL.

claims per 100 firms in 1970 was 63% greater than in 1960. Average claim value in 1970 was nearly 56% greater than in 1960.

Tables I and II show the history of the value and volume of architecture and engineering claims under the AIA-NSPE Program in more detail.

TABLE I
ARCHITECTS AND ENGINEERS PROFESSIONAL LIABILITY INSURANCE* AVERAGE CLAIM VALUE BASE YEAR — 1960

Year	Average Claim Value
1960	100.0%
1961	69.9%
1962	106.1%
1963	89.9%
1964	87.4%
1965	90.0%
1966	121.2%
1967	119.9%
1968	125.6%
1969	146.0%
1970	155.8%

*Table provided by Victor O. Schinnerer, Inc., Administrator of AIA-NSPE Insurance Program.

The average claim value is the average amount of claim payments and claim expenses of each claim occurring in each year of the program.

The results include all insured firms (approximately 10,000 firms as of 1971) and are expressed as percentages of the base year of 1960 to reflect the upward trend of the average claim.

Table I shows that the increases in the average architecture and engineering malpractice claim value took place between 1965 and 1970 rather than in the first half of the 1960's. These increases may have been due, in part, to general economic inflation during those years. On the other hand, frequency of claims as shown in Table II increased by a larger proportion between 1960 and 1965 than between 1965 and 1970.

The bulk of the professional liability claims and suits agains architects and engineers involved in construction arise from instances in which they are alleged to be responsible for defects in the design of structures and, therefore, liable for the cost of remedial work to correct the defects.

Unlike medical malpractice, where nearly all cases are personal injury claims, only about 15 percent of the claims and 18 to 20 percent of the payments under the AIA-NSPE professional liability insurance program involve personal injury. A number of the personal injury claims that do arise reportedly result from instances in which construction workers who are injured on the job are prevented from bringing legal action against their employers because of Workmen's Compensation laws. The workers sometimes turn to the architect or engineer as a possible avenue for financial redress for losses they feel are not covered by Workmen's Compensation payments.

TABLE II
ARCHITECTS AND ENGINEERS PROFESSIONAL LIABILITY INSURANCE* FREQUENCY OF CLAIMS PER 100 FIRMS

Calendar Accident Year	Frequency Per 100 Firms
1960	12.7
1961	13.1
1962	14.6
1963	13.2
1964	15.4
1965	17.6
1966	17.7
1967	18.8
1968	18.7
1969	20.0
1970	20.6

*Table provided by Victor O. Schinnerer, Inc., Administrator of AIA-NSPE Insurance Program.

Frequency of claims per 100 firms is the average number of claims incurred by each 100 firms.

Although the alleged events are in entirely different spheres, architecture and engineering malpractice cases, like medical malpractice cases, are often complex and involve judgments as to the standard of professional conduct of the practitioner. For architects and engineers involved in construction, cases are further complicated by relationships with and reliance on contractors and subcontractors. In addition, architects and engineers have no control over how structures they design for a specific purpose might eventually be used.

Increases in the volume and value of claims against architects and engineers have caused the yearly ultimate incurred loss figure[2] for the AIA-NSPE program to skyrocket over the 1960-1970 period. As Table III shows, the program's 1970 ultimate incurred loss was nearly seven times its ultimate incurred loss in 1960.

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[2] The ultimate incurred loss is the total amount of all claims and legal expenses occurring in each year as actuarially projected to their final settlement.

TABLE III
ARCHITECTS AND ENGINEERS PROFESSIONAL LIABILITY INSURANCE* ULTIMATE INCURRED LOSS BASE YEAR - 1960

Year	Ultimate Incurred Loss
1960	100.0%
1961	92.3%
1962	222.5%
1963	173.3%
1964	192.0%
1965	227.2%
1966	318.5%
1967	356.0%
1968	398.1%
1969	566.7%
1970	693.2%

*Table provided by Victor O. Schinnerer, Inc., Administrator of AIA-NSPE Insurance Program.

The basic insured unit under the AIA-NSPE program is the architecture or engineering firm. Rates vary according to the size of the firm and the volume of work it does. As with medical malpractice insurance, rates also vary according to geographical location, the type of professional services rendered, and the loss experience of the insureds. Firms can choose from a variety of liability limits and deductibles.

Table IV shows how premium rates have increased over their 1960 level, from 1961 through 1970. Since 1970, premium rates have continued to increase. They went up 33 percent from 1970 to 1971 and an additional 10 percent from 1971 to 1972.

The large jump in rates between 1967 and 1968 reflects a crisis that occurred in the program in the latter year. In analyzing its first ten years of underwriting the program, the carrier discovered a $9,000,000 underwriting loss. Most of the loss had occurred within the first $100,000 layer of insurance. Actuaries estimated that losses would continue to increase at the rate of 20 percent for each of the next three years. Because of the high and unpredictable nature of the losses and the expected adverse future trend, the carrier felt it could not continue to write the insurance under the same terms as in the past. A moritorium was declared on issuing new policies pending resolution of the crisis. Since alternative coverage is offered only by a few small companies in limited areas, architects and engineers are dependent on the AIA-NSPE insurance program and the moritorium caused a great deal of concern. Studies were instituted and meetings were held on the problem.

TABLE IV
ARCHITECTS AND ENGINEERS PROFESSIONAL LIABILITY INSURANCE* AVERAGE PREMIUM RATE LEVEL INCREASES BASE YEAR - 1960

Year	Premium Rate Level
1960	100.0%
1961	100.0%
1962	130.5%
1963	134.0%
1964	142.8%
1965	142.8%
1966	142.8%
1967	157.8%
1968	236.7%
1969	284.0%
1970	391.9%

*Table provided by Victor O. Schinnerer, Inc., Administrator of AIA-NSPE Insurance Program.

The above table illustrates the cumulative percentage rate increases for the period shown.

The result of the crisis was a new system that included a "reserve premium plan," requiring policy holders to pay an amount equal to 25 percent of their premium for the first $100,000 of coverage in addition to their basic premium. Only coverage with policy limits of $100,000 or more is sold. In accordance with formulae approved by each state insurance department, the "reserve premium" is used to pay excess bases. Any unused portion of it is returned to policy holders. In 1971 the carrier began crediting annual interest on the reserve premium account at the rate of 4%.

In dealing with their insurance crisis, the AIA and NSPE took the attitude that the ultimate answer to improving their professional liability situation lay in improving the quality of their professional services. In a letter to the association membership following a study of the 1968 crisis, the AIA Committee on Insurance said:

> Basically, it is not the insurance company which establishes high rates. The errors and omissions of architects and engineers in their work have made this a difficult and expensive program. A few well publicized cases have

> occurred where the professional has, in substance, been the victim of the social and legal climate of our times. The majority of cases, however, are those in which there have been failures of the professionals to properly do their work. Schools in their training, and the registration boards in their examinations, are urged to give more attention to what the courts and the public are holding the architects and engineers and other professionals accountable for, and make necessary adjustments in their educational and examining processes.

In this spirit the AIA and NSPE, in cooperation with the insurance adminstrator and carrier, instituted a loss-prevention program in the form of a series of publications entitled "Guidelines for Improving Practice." Publication of the series began in January 1971. The guidelines are aimed at contributing positive suggestions for improving professional practice and office organization. Hopefully, the suggestions are ones which can be incorporated by each firm in its own practice. In commenting on the program in a newsletter to AIA members, Carson M. Cornbooks, then Chairman of the AIA Committee on Insurance, said:

> "We hope the stormy social and legal climate will improve. However, we must be realistic and recognize that our influence over these areas is minimal. Our major area of influence is in improving the professional liability picture for architects and engineers in our own offices."

There has been some evidence that the professional liability picture for architects and engineers is brightening somewhat. At least, it appears to be getting worse at a slower rate. Contrary to 1968 predictions that losses would increase at the rate of 20 percent every year, the loss increase from 1970 to 1971 was only 16 percent and the estimated loss increase from 1971 to 1972 is 13 percent. The professional associations now say that they have hope for a leveling off of professional liability claims and suits against architects and engineers in the future. In addition to the possible effects of their loss prevention program, they point to what they see as a somewhat improved legal climate, including the more frequent upholding of statutes of limitation, and to more experienced and expert defense attorneys, as both evidence and explanation of the improving trend.

Lawyers

The legal profession, while concerned about the rising trend toward increasing legal malpractice claims and suits and higher insurance premiums, does not appear to feel that its professional liability problems have reached crisis proportions. Although awards and settlements in legal malpractice cases can be substantial, individual payments do not reach the huge sums that are sometimes involved in medical, accounting, architecture, and engineering *professional liability* cases. In its 1971 study of legal malpractice, for example, Jury Verdict Research, Inc., a firm that gathers and analyzes the results of jury verdicts across the country, found the highest legal malpractice verdict up to that time to be $162,500.[3]

The history of legal malpractice premium rates since 1961 has been mixed, depending on geographical location. Table V, dealing with legal malpractice premium rates since 1961 in the 50 states, the District of Columbia, and Puerto Rico, is based on rates published by the Insurance Services Office (ISO), a data-gathering, rate-filing, and rate-setting association for insurance companies. ISO rates for all the jurisdictions were approximately the same in 1961.

The table shows that legal malpractice insurance rates remained virtually unchanged during the first half of the 1960's. Between 1961 and 1965 only one jurisdiction experienced a rate increase and two jurisdictions experienced rate decreases. Even as late as 1968, over 71% of the jurisdictions still retained their 1961 legal malpractice insurance rates, and where rates had increased the rises had generally been less than 50% of the 1961 rates. The acceleration in the number and size of rate increases seems to have begun in 1969. By the end of that year, over 64% of the jurisdictions showed rates above their 1961 levels and rates had doubled or more than doubled over their 1961 levels in 17 percent of them. By the end of 1970, 72% of the jurisdictions showed rates higher than in 1961 and rates had doubled or more than doubled over their 1961 levels in some 35 percent of the jurisdictions.

When we examine Table VI, below, to see where the increases took place, we see that, contrary to what might be expected, no strong rural/urban cleavages are apparent. Although most of the jurisdications experiencing no rate increases between 1961 and 1970 are rural ones, other rural jurisdictions sustained higher rate increases than many urban states.

Some legal specialities, notably securities, patent, tort, and real estate law, are considered higher professional liability risks than others. Higher rates may be charged for practitioners who specialize in these areas, deductible limits increased for them, or, as in the case of the insurance program sponsored by the Florida Bar Association, firms with a high proportion of their practice devoted to certain specialities may be ineligible for coverage.

Although legal malpractice claims can arise from a variety of circumstances, experts estimate that over half of them relate to failure of an attorney to take a particular legal action before the running out of the applicable statute of limitations. Risk control programs organized by insurance carriers, administrators, and legal associations have been aimed at developing loss-prevention activities that would hit at this and other problems. The efforts include making suggestions for improved office practices and developing peer review mechanisms and educational programs. Those involved in the legal malpractice field cite a need for more risk control programs.

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[3] "Malpractice Part III," *Personal Injury Valuation Handbooks,* Vol. 3A, No. 130 (Cleveland, Ohio: Jury Verdict Research, Inc., 1971), p. 713.

TABLE V
FREQUENCY DISTRIBUTION OF THE PERCENT OF INCREASE IN LEGAL MALPRACTICE INSURANCE RATES DEMONSTRATED BY 52 JURISDICTIONS
BASE YEAR - 1961*

Percent of Increase	1962	1963	1964	1965	1966	1967	1968	1969	1970
Above 300%									1
250%-299%									1
200%-249%									
150%-199%								3	5
100%-149%								6	11
50%-99%					1	1	2	10	8
1%-49%			1	1	11	13	13	14	11
No Increase	52	52	49	49	40	38	37	19	15
Decrease			2	2					

YEAR

*Table based on a listing of ISO rates provided by the St. Paul Insurance Companies, St. Paul, Minnesota.

TABLE VI
INCREASES IN LEGAL MALPRACTICE INSURANCE RATES IN 52 JURISDICTIONS BETWEEN 1961 AND 1970

NO INCREASE	UNDER 50% INCREASE	50%-99% INCREASE	100%-149% INCREASE
Idaho	Alabama (43%)	Arizona (51%)	Arkansas (100%)
Kentucky	Colorado (43%)	Georgia (51%)	Florida (100%)
Missouri	Delaware (31%)	Illinois (57%)	Iowa (100%)
Nevada	District of Columbia (43%)	Maine (86%)	Minnesota (100%)
North Carolina	Indiana (29%)	Michigan (86%)	New Mexico (100%)
North Dakota	Kansas (43%)	Nebraska (51%)	New Jersey (129%)
Oklahoma	Massachusetts (40%)	Ohio (86%)	Vermont (100%)
Puerto Rico	Mississippi (14%)	Pennsylvania (86%)	Virginia (100%)
Rhode Island	Tennessee (40%)		Washington (111%)
South Carolina	West Virginia (43%)		Wisconsin (143%)
South Dakota	Wyoming (14%)		Hawaii (100%)
Texas			
Utah			
New Hampshire			

150%-199% INCREASE	200%-299% INCREASE	300% INCREASE OR MORE
Alaska (186%)	California (275%)	Oregon (300%)
Connecticut (186%)		
Louisiana (186%)		
Maryland (174%)		
New York (154%)*		

*Except for New York City where increase was 180%

No national profession liability insurance program exists for attorneys, although a number of state and local bar associations do sponsor insurance programs for their members. The American Bar Association, as well as many state and local legal groups, would like to sponsor a professional liability insurance program but has had difficulty finding recognized, responsible carriers willing to provide coverage under the terms it considers acceptable. Except for two large national carriers, few major companies write legal malpractice insurance.

Generally, policies written under state and local group-sponsored programs offer better coverage and lower rates than conventional policies. To provide a sampling of what these programs offer, those sponsored by the Florida Bar Association, the Illinois Bar Association, and the Lawyers Club of San Francisco are described below.

The professional liability program of the Florida Bar Association began approximately four years ago. Its premium rates have risen once, from $109 to $144 for $100,000/$300,000 coverage for both an attorney and his firm and from $47 to $61 for coverage at the same level for the firm only, for liability incurred by an employed attorney. The policy carries no deductibles. Firms whose principals purchase insurance are insured for any allegedly negligent acts committed by their secretaries and office clerks at no extra charge.

The Illinois Bar Association has been affiliated with a legal malpractice insurance program for 12 years. Currently the Association is in the second year of a contract under which a major carrier agreed to write insurance for Illinois Bar Association members for a five-year period, with three 10% rate increases during the five years. The basic 1972 premium rate for $100,000/$300,000 coverage with a $1,000 deductible is approximately $184 per year for a single practitioner. Firms with two or more attorneys are charged approximately $168 per man for the same coverage. In addition, a $1,000,000 umbrella option is available under the program. Consideration of the insured's type of practice and claim history may result in higher deductibles for some policy holders.

The Lawyers Club of San Francisco sponsors an insurance program open to its members and the members of the bar associations of the California counties of Los Angeles, Orange, San Diego, Marin, Contra Costa, Santa Clara, San Mateo, and Monterey. Three years old, it offers $100,000/$300,000 professional liability coverage according to the number of principals and employed attorneys insured, at the following rates:

One	Two	Three	Four	Five	Each Additional
$266	$406	$575	$722	$846	$169

Liability limits of $300,000/$900,000 and $1,000,000/$1,000,000 are also available, at higher rates.

The program provides for a 25 percent rate surcharge for attorneys who handle Securities and Exchange Commission reports. Attorneys who hold preceeding insurance that expires on or after the effective date of their new policies under the Lawyers Club of San Francisco program are eligible to purchase coverage extended to prior acts for an additional 50% charge. Attorneys who customarily practice in other states are not eligible to participate in the program. The only deductible in the policy is a $1,000 one, effective only in cases of counterclaims in suits for collection of fees.

Accountants

Professional liability has also become a matter of serious concern for accountants in recent years. The American Institute of Certified Public Accountants reports that accounting malpractice claims and suits have been increasing. Neither the Insurance Services Office nor, to our knowledge, any other national organization collects rate information on accounting malpractice insurance on a nationwide basis. One insurance company spokesman, however, reported that premium rates for accountants had almost doubled in the last four years. He also estimated that close to 75% of all practicing accountants now carry professional liability coverage.

Accounting malpractice cases may arise from a variety of circumstances, including alleged inadequate disclosures in audit statements on which credit is issued or alleged failure of an auditing accountant to uncover and report embezzlement. Awards in some cases have run nearly as high as five million dollars. Cases resulting from class actions, often involving alleged errors in auditing statements used for Securities and Exchange Commission filings, can be very costly. Smaller cases often involve late tax filings.

Reportedly, only a few insurance carriers are active in writing professional liability coverage for accountants. To guarantee the availability of coverage and to obtain preferred rates, the American Institute of Certified Public Accountants and a number of state and local accounting associations cooperate with insurance administrators and carriers to sponsor malpractice insurance programs for their members. Generally, the group affiliated programs are not open to large accounting firms. Rates in non-group affiliated programs vary according to geographical location, the size of the firm, and its claim history. Firms that perform audits for large public corporations are considered to be high insurance risks because they have the potential for generating giant claims. Generally, policies for small firms do not have deductibles while deductibles between $25,000 and $50,000 are commonly written into policies for large firms.

The insurance program sponsored by the American Institute for Certified Public Accountants is open to practice units with 50 or fewer employees with client contact. It insures about 10% of the Association's members. Rates paid by the firm are governed by the number of owners, partners, and employees engaged in work for clients. A 33% primary rate increase under the four-year-old program was effected in 38 states and the District of Columbia in 1971. In other jurisdictions, where insurance regulatory bodies did not approve the increase, rates remained at their previous level. New York and New

Jersey have carried higher rates than other jurisdictions since the program began.

The standard rate for a single practicing accountant (including the 33% increase) is $215 for himself or $238 for himself and his secretary for policy limits of $250,000/$500,000. Limits of $500,000/$1,000,000 are also offered under the program at higher rates, and excess limits of $1,000,000 are available for those who choose the $500,000/$1,000,000 primary coverage.

Although the AICPA would like to see a risk control program tied to its professional liability insurance plan, no cooperative arrangements for such a program have been made as yet. If risk control efforts were effected, AICPA would like them to include both continuing education and peer review.

Inter-Professional Comparison

Table VII, demonstrating increases in malpractice insurance rates between 1962 and 1972, is presented as a means for comparing medical malpractice trends with trends in professional liability in other professions. Physicians', surgeons', dentists', and lawyers' rates shown on the table are based on averages of the ISO rates of the individual states and territories of the United States.[4] Architects' and engineers' rates are based on nationwide averages of rates under the American Institute of Architects - National Society of Professional Engineers professional liability insurance program. Accountants' rates have not been included because nationwide information was not available. Dentists were included on the table as the non-physician health care profession considered to have the most serious malpractice problem.

According to the table, malpractice premium rates for physicians and surgeons do appear to have increased substantially more than premium rates for other professionals. Premium rate increases for architects and engineers, however, are shown to have been very severe as well. Malpractice insurance rates for lawyers appear to have increased at about the same rate as those for dentists.

Among all the professions, increases appear to have been relatively modest between 1962 and 1966, although they were more substantial for physicians and surgeons than for the other professions shown. The rate of increase in premium rates gathered momentum for architects and engineers as well as for physicians and surgeons between 1966 and 1968. Among all the professions, however, the highest rate of increase took place between 1968 and 1970. Since 1970, the rate of increase in premium rates appears to have tapered off to some degree.

If increasing malpractice insurance premiums indicate increased malpractice suits and claims, one may surmise that the acceleration of the malpractice problem in the medical profession in recent years is, at least in part, a reflection of a general increase in malpractice activity affecting other professions as well. Members of the medical profession, particular surgeons, however, appear to be feeling the effects of this general increase in malpractice activity most strongly. One could speculate too, that the increase in medical malpractice activity has had a spillover effect into other professions, in part causing the general acceleration in malpractice activity, as well as reflecting it. There is some evidence that the "malpractice problem" may be spreading to more unlikely professions as well. The American Chemical Society, for example, recently announced that it was planning to offer a professional liability insurance program for its members in the near future.

TABLE VII
MALPRACTICE INSURANCE RATES FOR LAWYERS, ARCHITECTS ENGINEERS; PHYSICIANS, SURGEONS, AND DENTISTS SHOWN AS PERCENTAGES OF 1962 RATES FOR EACH PROFESSION

	LAWYERS	ARCHITECTS/ ENGINEERS	PHYSICIANS	SURGEONS	DENTISTS
1962	100%	100%	100%	100%	100%
1964	99.0%	109.4%	115.8%	135.5%	100.3%
1966	106.9	109.4	134.0	157.1	115.9
1968	109.8	181.4	217.6	204.2	121.0
1970	170.7	300.3	540.0	673.9	164.4
1972	*	439.3	667.7	826.7	177.8

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[4] See "The Medical Malpractice Insurance Market", *Supra,* pp. 494 ff.

THE MALPRACTICE PROBLEM FOR NON-PHYSICIAN HEALTH-CARE PROFESSIONS AS REFLECTED IN PROFESSIONAL LIABILITY INSURANCE RATES

Beatrix W. Shear

Summary

If malpractice insurance rates can be used as evidence of the seriousness of the malpractice problem for different groups of health-care providers, one may generally validate an initial assumption that autonomous health-care providers have a more serious malpractice problem than supervised, employed health-care workers. As new allied health occupations with more autonomous roles emerge (i.e. physicians' assistants consulting pharmacists), one may assume that they will feel a need for malpractice liability coverage and that they will have to pay more than the more traditional supervised occupational groups for it, at least until they establish favorable actuarial histories. In addition, one may note that, as in the case of physicians, allied health-care workers involved in surgery and administering anesthetics generally have a more serious malpractice problem, and higher malpractice rates, than their counterpart professionals who are not involved in these "high risk" areas.

In spite of the reportedly low frequency of claims against supervised health-care personnel, most of their professional associations are aware of and, in varying degrees, concerned about malpractice, at least to the point of instituting or endorsing malpractice insurance programs for their members. Many of these programs are new and participation rates in some of them are quite low; but the fact that they exist bears witness to a perceived need for such coverage.

For now, medical malpractice appears to be largely the problem of health care institutions, physicians, and, to varying degrees, other autonomous health care providers. Its potential as a problem for supervised health care personnel does appear to be real, however, depending on the expansion of their duties and responsibilities their involvement with such high risk procedures as administering anesthesia, the kind of insurance provided by their employers, and the popularity of the practice of naming supervised health care workers along with physicians and institutions in malpractice claims and suits.

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Vast numbers of people other than physicians are employed in the health care field. Their jobs, training, and skills vary widely, but all can be considered health care professionals. This study was aimed at probing into how these various professions are faring in regard to professional liability. Only scattered information on malpractice claims in the allied health professions was found to be available. Information on malpractice insurance rates, however, was found for most of the professions and can be used as an indicator of the seriousness of the malpractice problem for each occupation group.

There are a number of potential groupings that can be made of the various allied health professions. Twenty-one professions were chosen for investigation. The grouping that appeared to be the most meaningful for a discussion on malpractice was the degree of autonomy of the practitioner. The discussion that follows uses such a breakdown.

Autonomous Health Care Professionals

As one might expect, professions composed largely of autonomous rather than supervised practitioners appear to be feeling the effects of malpractice claims most strongly, particularly when practitioners are self-employed. Under the doctrine of *respondeat superior*, the employer is held liable for the negligence of his employees. The self-employed, autonomous professional, however, is legally held to be solely responsible for his own acts.

Chiropractors, clinical psychologists, dentists, optometrists, physical therapists, podiatrists, and speech pathologists/audiologists fall into the general category of autonomous health care professionals. Although some of them practice in institutions or otherwise come under the direction of other health-care professionals, many, and in some professions most, practice solely under their own authority. Often, professionals in these occupations are responsible for supervising other health-care workers.

Malpractice insurance rates for all of these professions, with the exception of psychologists and speech pathologists/audiologists, are higher for self-employed practitioners than for employed practitioners. Average professional liability premium rates are frequently difficult to compute accurately because they are sometimes included in "package" insurance programs that offer premises, product, and personal, as well as professional, liability coverage. In addition, premium rate variations related to geographical location and professional speciality are common.

Since the data on rates, and in some cases claims, in each profession are not available on a strictly comparable basis, it may be more useful to look at each professional group individually.

Chiropractors

Most members of the American Chiropractic Association are insured under the association-sponsored program. The annual premium rate for a single-practice chiropractor for \$200,000/\$600,000 coverage is \$180. Basic rates for the association program have not risen since 1947, but higher ranges of liability limits under the program were made available in more recent years.

Rates published by the Insurance Services Office (ISO) an information-gathering, rate-filling, and rate-setting organization for insurance companies, are as follows for \$100,000/\$300,000 coverage for chiropractors.

Private practice chiropractor	\$123.00
Employer's liability for each employed chiropractor	\$ 30.90
Partnership liability	\$ 24.72

Clinical Psychologists

The American Psychological Association estimates that of its approximately 35,000 members, some 12,000 could be considered clinical psychologists, doing either full-time or part-time work that involves patient contact. It further estimates that approximately 3,000 of the clinicians are in private practice, either full or part-time.

A spokesman for the association said that malpractice is not currently considered a serious problem by the profession, but Mr. Paul O'Brien of the APA Insurance Trust indicated that a trend toware more claims for larger sums may be developing. A recent \$170,000 judgment against a psychologists is the highest award or settlement in the 15-year history of the APA malpractice insurance program.

Open to private practicing as well as employed psychologists of all types, the program offers a range of liability limits from \$100,000/\$300,000 to \$300,000/\$900,000 at rates ranging from \$30 to \$40. No special rates for various geographical locations or psychological specialities are in effect. Mr. O'Brien estimates that over half of the six to seven thousand subscribers to the program are clinicians.

Although no rate increases have occurred in the program since it began, a provision was added recently excluding liability coverage for physical injury generated by rage-reduction therapy or other treatment that involves physical assaults on the patient. Liability resulting from shock therapy, which legally can be administered only by physicians, has always been excluded under the APA program. A recent expansion of the program provides liability coverage for alleged negligent analysis of test results.

Reportedly, malpractice insurance for individual psychologists is not readily available outside the APA program, although it is written by a few companies. Mr. O'Brien estimates that most psychologists who carry their own insurance policies purchase them through the APA program. Many employed clinical psychologists are believed to be insured under the policies of the clinics, hospitals, or other facilities where they work.

Dentists

The vast majority of dentists are self-employed and engaged in individual or group practices, either as principals or associates. Malpractice insurance rates vary according to geographical location. In addition, rates are higher for oral surgeons than for dentists who do not perform surgery that requires the administering of a general anesthetic. Dentists who do x-ray therapy work must pay additional charges for coverage. Average ISO-published rates for dentists practically doubled between 1960 and 1971, rising from $66.10 to $123.40 for $100,000/$300,000 coverage for dentists whose practices include surgery.[1]

The Professional Protection Plan of the American Dental Association is of the package variety. It provides various kinds of protection, including insurance against damage to the dentist's equipment and office premises, in addition to professional liability. Its premium rates, although varying greatly from one dentist to another, have not increased in the past three years. Only a relatively small percentage of dentists, however, appear to use it.

Fuller information on the volume, value, and types of malpractice cases in which dentists are involved can be found in the Commission's closed claim study.[2] Additional claims data, based on the American Dental Association's program, is also of interest. Between January, 1971 and January, 1972, 3,710 dentists subscribed to the ADA plan. A total of 55 professional liability claims were reported during that period, yielding a ratio of just under 1.5 claims for every 100 dentists enrolled. Payments and reserved funds for payment stemming for the claims reached the sum of $113,650. From January 1, 1972 to October 10, 1972, a total of 6,210 insureds were enrolled in the program. Some 51 claims for professional liability were reported during that period, but incurred losses have been much lower than in the previous year, totaling only $28,352 through October[3].

Optometrists

According to the American Optometric Association's Committee on Insurance, approximately 9,000 optometrists hold professional liability policies. Most of these policies are written by two large insurance carriers.

Only some 1,115 of those who are insured out of the AOA's active membership of 12,702 carry the "umbrella package" endorsed by the association. The plan covers professional liability for alleged negligence on the part of the insured and his employees to limits of $100,000/$300,000. In addition, it provides product and office premises liability protection and $1,000,000 umbrella coverage over and above insured's other policies. The estimated rate for the average optometrist is $110 per year. Professional equipment insurance can be purchased at extra cost.

A spokesman for the American Optometric Association said that, so far, optometry has not been faced with many serious claims, although the volume of claims has increased somewhat with the advent of contact lenses.

ISO rates for $100,000/$300,000 professional liability coverage for optometrists is as follows:

Private practice optometrist	$15.50
Employer's liability for each employed optometrist	$ 3.88
Partnership liability (per optometrist partner)	$ 3.10

Physical Therapists

The American Physical Therapy Association estimates that approximately one-quarter of all practicing physical therapists are in private practice, often working on a contract basis with hospitals, nursing homes, and public health agencies. Professional liability insurance rates, either through the American Physical Therapy Association program or through independent, non-affiliated brokers vary, depending on the size of the physical therapy practice, the number and kinds of employees the practice has, the kinds of contractual arrangements under which it works with hospitals or other institutions, and its claims history. Minimum policy limits under the association-affiliated program is $70,000. Coverage up to $1,000,000 is available.

ISO rates for proprietary physical therapists for $100,000/$300,000 coverage are as follows:

Physical therapist	$82.40
Employer's liability for each employed physical therapist	$20.60
Partnership liability (per physical therapist partner)	$16.24
Physical therapist in active military service	$41.20
Physical therapist employed full-time by U.S. government ...	$61.80

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[1] More detailed information on dental malpractice insurance is included in "The Malpractice Insurance Market", *Supra*, pp. 494 ff.

[2] "Medical Malpractice Insurance Claims Files Closed in 1970", *Supra*, pp. 1 ff.

[3] Statistics provided by W.F. Poe Associates, Inc. National Administrators: The Professional Protection Plan, American Dental Association, November, 1972.

Professional liability insurance rates of employed physical therapists for their own liability in malpractice cases are more uniform than rates for proprietary physical therapists. For $200,000/$600,000 coverage under the American Physical Therapy Association program, the premium rate is $30. Approximately 2,646 association members subscribe to the association's plan. Until 1970, employed as well as self-employed physical therapists were charged a blanket $45 for the same coverage. When self-employed therapists were separated out from the standard association insurance program, premium rates for employed therapists went down.

In a 1970 article, Mr. Charles A. James, vice-president of Maginnis and Associates, broker for the American Physical Therapy Association - endorsed program, reported that at that time the rate of claims under the program was averaging five per month. The claims were generated by the following causes: patient falls, 28%; heat, 18%; equivalent failures, 12%; equipment falling or dropping, 6%; direct patient contract, 24%; and other causes, 12%. Injuries were: fractures, 26%; burns, 18%; strains and sprains, 10%; abrasions and lacerations, 13%; bruises, 22% and miscellaneous, 11%.[4]

Between July 1, 1971 and July 1, 1972 some 45 claims were made against insureds in the APTA professional liability program. The total paid out or set aside in reserves for fiscal 1971 was $25,000; for fiscal 1970 it was $34,000.

The ISO rate for employed physical therapists for their own professional liability protection is $41.20.

Podiatrists

Insurance rates for $100,000/$300,000 coverage under the American Podiatry Association's 27 year old professional liability program have increased approximately 60% since 1966 in most states. The association feels this is a modest increase, considering the recent malpractice experience of other medical professions. The table below demonstrates, however, that certain states and territories have sustained considerably more substantial increases in premium rates than the bulk of jurisdictions and that rates for podiatrists who perform surgery are considerably higher than rates for those who do not.

The American Podiatry Association feels that the general trend toward increasing medical malpractice claims and suits may not have been reflected fully in the association insurance program rates as yet and that rates will increase in the future as more malpractice cases from previous years are concluded.

In addition to $100,000/$300,000 coverage, liability limits of $200,000/$600,000 and $500,000/$1,500,000 with an optional $1,000,000 umbrella are available under the association program. At all levels, individual surcharges are applied to insureds with prior loss histories.

ISO rates for $100,000/$300,000 coverage for podiatrists are as follows:

Private practice podiatrist	$206.00
Employer's liability for each employed podiatrist	$ 51.50

RATES FOR $100,000/$300,000 COVERAGE FOR
PROFESSIONAL LIABILITY INSURANCE PROGRAM
OF THE AMERICAN-PODIATRY ASSOCIATION*

	All Other States		D.C., ILL., WA. N.J., ORE., HA. P.R.		N.Y., MICH., FLA. (DADE CO.)		CALIFORNIA	
	Non-Surgical	Surgical	Non-Surgical	Surgical	Non-Surgical	Surgical	Non-Surgical	Surgical
1966	117.42	117.42	117.42	117.42	117.42	117.42	117.42	117.42
1968	155.00	155.00	178.00	207.00	207.00	232.00	232.00	232.00
1970	155.00	232.00	178.00	267.00	207.00	310.00	232.00	348.00
1972	189.00	284.00	218.00	327.00	251.00	377.00	360.00	720.00

*Statistics based on report, "American Podiatry Association Professional Liability Program", submitted to the Secretary's Commission on Medical Malpractice by the American Podiatry Association.

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[4] Charles A. James, Jr., "Medico-Legal Considerations in the Practice of Physical Therapy," *Physical Therapy*, The American Physical Therapy Association, Vol. 50, No. 8, August, 1970, p. 1203.

Partnership liability (per podiatrist partner)	$ 41.20
Podiatrists active in U.S. military	$103.00
Podiatrists employed full-time by the federal government	$154.00

It must be noted, however, that insurance at these ISO rates may not be available to all podiatrists, in all states. The American Podiatry Association points out that the association's ability to maintain its program has been strengthened by the flexibility of its group arrangement. This arrangement allows for adjustment in rates when increases in claims activity warrant them, without prior approval of state insurance departments.

Speech Pathologists—Audiologists

Approximately 10,000 to 11,000 practicing clinical speech pathologists/audiologists are members of the American Speech and Hearing Association. Almost all of them hold degrees at the Masters level or above. Although they are autonomous professionals, working independently from physicians, the ASHA estimates that less than 2,000 of them are in private practice. Most work in hospitals, speech and hearing clinics, or school systems.

ASHA members are eligible for participation in an association-sponsored malpractice insurance program that provides professional liability coverage up to $200,000/$600,000 at an annual premium rate of $27.50, except in Florida, Oregon, Washington, and Pennsylvania, where the rate is $28.33. A private practice speech pathologist or audiologist can insure himself against liability for the negligent acts of his speech and hearing professional employees at an additional $7.00 per year per named employee. Partnership insurance under the program costs $8.00 per year. Corporate entities may obtain coverage by applying under a separate ASHA program in which premiums are determined according to the nature of the individual corporation. Only about 700 insureds participated in this program, however. The society believes that coverage is also available from individual brokers not tied to the association-endorsed program. The non-affiliated coverage, however, is believed to be more expensive than the association-endorsed program and, therefore, not widely purchased. Undoubtedly, a number of speech pathologists and audiologists are insured by their employers.

Professional liability is not perceived as a serious problem in the speech and hearing professions. There have been few claims under the ASHA-endorsed program. Rates for the program have, in fact, gone down since it was initiated several years ago.

ISO does not publish professional liability premiums rates for the speech and hearing professions.

Audiologists who practice in a specialized branch of speech and hearing pathology that involves the use of equipment and the direct physical manipulation of patients to a greater extent are considered more vulnerable to malpractice claims and suits than other speech and hearing pathologists. Certain procedures, the making of plaster of Paris earmold impressions, for example, are considered somewhat risky in malpractice terms.

Naturopaths and Mohelim

Two other small groups that can be considered autonomous health care professionals are naturopaths, (nonphysicians who treat illness with herbs and special diets), and mohelim (religious practitioners who perform ritual circumcisions for male children of the Jewish faith).

In 1970, naturopaths organized into the International Naturopathic Association, with approximately 500 members in the U.S., Canada, Mexico, and Australia. The group's president, Mr. Joseph M. Kadams, of Las Vegas, Nevada, reported that he did not believe malpractice was a serious problem for naturopaths and that he believed most naturopathic practitioners did not carry professional liability insurance. He felt, however, that the association would be interested in making arrangements for a group-affiliated insurance program and that such a program would be supported by naturopaths if it was available.

The Brith Milah Board of the New York Board of Rabbis reported that mohelim were concerned about malpractice coverage, although suits and claims against them are rare. Training programs and qualifications for mohelim vary. Few carriers, according to the board, are willing to write appropriate coverage.

Christian Science Practitioners

Christian Science practitioners, who treat ill patients through prayer and religious reading, are not insured against malpractice, according to the Christian Science Center at the First Church of Christ Science in Boston. The Church feels that there is no need for the practitioners to be insured, since they have no physical contact with patients and do not advise them about the desirability of accepting or refusing medical treatment.

The approximately one dozen Christian Science sanitariums across the country, and the Christian Science nurses who work there, are generally covered by malpractice liability insurance, however, according to the center.

Pharmacists and Opticians

Pharmacists and opticians represent a somewhat special class of health care personnel. They are not autonomous inasmuch as they generally carry out the instructions of physicians or other autonomous health care providers rather than perform their own diagnoses and formulate their own treatment plans. They are, however, autonomous in the sense that they are not directly supervised. In addition, a considerable number of professionals in these fields are proprietors of drug stores and optical establishments, and thus are exposed to a larger degree of professional liability than most supervised or employed health care workers.

Insurance rates for proprietary druggists and opticians are figured according to the total annual receipts of their retail establishments. ISO rates for $100,000/$300,000 professional liability coverage for optical establishments are $.38 per $1,000 of annual receipts with a $29.45 minimum rate for establishments with $75,000 of annual receipts or less.

ISO rates for proprietary druggists vary according to geographical location as well as claims history and policy limits.

It should be noted that these "proprietary" policies are oriented toward product liability and the proprietor's own liability for alleged negligence, by himself or his employees, in dispensing pharmaceuticals and optical devices. Without special endorsements, the policies generally do not provide protection for the employed pharmacist or optician if he is sued in his own right.

Under ISO rates, employed opticians can purchase $100,000/$300,000 coverage for an annual premium of $20.60. A spokesman for the Opticians Association of America reported that no national associations sponsor professional liability insurance programs for opticians at the present time. He estimated, however, that many opticians do carry malpractice insurance and mentioned that his association was currently looking into the possibility of sponsoring an insurance program.

Employed pharmacists can obtain professional liability coverage for themselves through a program sponsored by the American Pharmaceutical Association. Liability limits of $200,000/$600,000 are available at a yearly premium of $15.00.

Pharmacists who practice only in hospitals are generally considered slightly better profession liability risks than those who practice in the community. The American Society of Hospital Pharmacists sponsors a professional liability program in which protection up to $200,000/$600,000 is available to pharmacists who practice in hospitals only for $10.00 yearly. Under the ASHP program, however, pharmacists who combine hospital and community practice must pay the same $15.00 premium rate that is charged in the American Pharmaceutical Association program. Some 2,009 pharmacists are enrolled in the American Association of Hospital Pharmacists program.

Pharmacy associations point to a new concern with professional liability, particularly as pharmacists branch out into consulting, administering drugs, and taking on other new roles as members of health care teams with doctors and nurses.

A relatively new type of specialist is the self-employed consultant pharmacist. He undertakes a broadened professional role in helping prescribe medications as well ad dispense them. The American Society of Consulting Pharmacists sponsors a program offering $200,000/$600,000 coverage, plus $50,000 property damage protection, to the self-employed consultant pharmacist for alleged negligence against himself or his employees. The premium rate is $91.00 per year. Coverage at the same limits for the self-employed consultant pharmacist, alone, is sold at $76.00 per year.

Supervised Health Care Personnel

Nurses in a wide variety of specialties, x-ray technologists, medical technologists, dental hygienists, inhalation therapists, occupational therapists, dieticians, physicians' assistants, medical assistants (secretaries, receptionists, aides and others who work in hospitals and in the offices of autonomous health care practitioners), and operating room technicians compose a category of health care personnel who generally perform their duties under the supervision of a physician or dentist. Most are employees rather than self-employed practitioners. Often, they work in hospitals or clinics or in offices of physicians, dentists, or other autonomous health-care personnel.

Because they are employed and supervised, malpractice actions arising out of their alleged negligence often fall under the *respondeat superior* doctrine. Because the employer is likely to have considerably more substantial financial resources he is almost always named in a malpractice claim against a supervised employee and he usually must provide most or all of the financial compensation that may result from the claim.

With this in mind, most hospitals, clinics, physicians, dentists, and other autonomous health care personnel insure themselves for liability for for negligence committed by their employees. Although no statistics are available to demonstrate it, increases in malpractice insurance premiums for physicians and other autonomous health care providers may be, in part, a reflection of a higher incidence of claims and suits against the employees they supervise. A sizable portion of the malpractice suits and claims against hospitals doubtless stem from the alleged negligence of supervised health care personnel.

The *respondeat superior* doctrine, however, does not abolish the individual liability of the supervised employee. Supervised employees may be named in malpractice suits or claims in their own right. If this happens, and if his employer's insurance policy does not provide for protection for him, the supervised employee may be forced to absorb the cost of legal fees to defend himself and all or part of any payment that results from the case.

Even if the supervised employee is not named in the claim or suit, he may be held liable by his employer in a subrogation suit for the financial loss the employer suffered on his account.

To protect themselves from such financial dangers, as well as from malpractice claims or suits that might arise when they are administering professional health care services outside the scope of their employment, some supervised employees purchase their own professional liability insurance, often through special programs sponsored or endorsed by their professional associations.

The following table lists the supervised health care professions and indicates the cost of malpractice insurance for their own liability. Premium rates for group-affiliated programs tend to be lower than rates on the regular insurance market, of which ISO-published rates are an indication. Although membership in the sponsoring organization is required for participation in most of the group-affiliated insurance programs, two of the largest ones, those sponsored by the American Nursing Association and the National Association of Licensed Practical Nurses, are open to non-member nurses as well. For most of the supervised health care occupations, premium rates do not vary from jurisdiction to jurisdiction.

The table shows that insurance rates for supervised health-care personnel, especially rates in programs sponsored or endorsed by professional associations, are generally low. The low rates, in turn, indicate that the volume and value of malpractice claims against supervised health care workers, themselves, have not been severe in most cases.

A major exception to this trend is the nurse anesthetist. Her current rates are nearly three to four times those paid by other supervised health care workers and, according to the administrator of the American Association of Nurse Anesthetists professional liability insurance program, her rates are about to increase again, substantially, to $108 per year for the basic $200,000/$600,000 coverage, plus an additional $79 for optional $1,000,000 umbrella coverage. The insurance administrator reports that these high premium rate levels are caused not by a large volume of claims against nurse anesthetists but by a relatively few very large claims, some going as high as $200,000.

PROFESSIONAL LIABILITY INSURANCE RATES FOR SUPERVISED HEALTH CARE PERSONNEL

Profession	ISO Rate (100/300 Limits Except Where Specified)	Association Rate (200/600 Limits Except Where Specified)	Association Name
Dental Hygienist	$20.60	$10.95	American Dental Hygienists Association
Dietician		10.33	American Dietetic Association
Inhalation Therapists		10.95	American Association for Inhalation Therapy
Medical Assistants		10.33	American Association of Medical Assistants, Inc.
Medical Technologists		15.00	American Society for Medical Technology
Nurses (R.N.)*	10.30	5.50 for (5/15)	American Nursing Association (association membership not required)
Nurses (R.N. L.P.N)*	10.30	10.00** (100/300)	National Federation of Licensed Practical Nurses (association membership not required)
Nurses (L.P.N., R.N., cont.)*	$10.30	$10.95	National Association of Practical Nurse Education & Service
Nurse Anesthetists	61.80	43.80	American Association of Nurse Anesthetists
		39.00**	National Federation of Licensed Practical Nurses

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*Excluding nurses administering anesthetics and x-ray therapy; private duty nurses are eligible for coverage at the same premium rates as employed nurses

**In Alaska, Hawaii, New York, Louisiana and Puerto Rico rates slightly higher

PROFESSIONAL LIABILITY INSURANCE RATES FOR SUPERVISED HEALTH CARE PERSONNEL (continued)

Profession	ISO Rate (100/300 Limits Except Where Specified)	Association Rate (200/600 Limits Except Where Specified)	Association Name
Critical Care Nurses		10.95	American Association of Critical Care Nurses
Industrial Nurses		11.00	National Association of Industrial Nurses
Nurse Midwives		10.95	American College of Nurse Midwives
Occupational Therapists		15.00	American Occupational Therapy Association
Operating Room Nurses		10.95	American Association of Operating Room Nurses
Seventh Day Adventist Nurses	$10.95	$10.95	Association of Seventh Day Adventist Nurses
Nurses Administering X-Ray Therapy	61.80		
Operating Room Technicians		10.95	Association of Operating Room Technicians
Physician's Assistants	$16 - $168.50 for 5/15 coverage depending on geographical location		
X-Ray Technologists	20.60	15.00	American Society for Radiologic Technology

*Excluding nurses administering anesthesia or x-ray therapy; private duty nurses are eligible for coverage at the same rates as employed nurses

**In Alaska, Hawaii, New York, Louisiana and Puerto Rico rates slightly higher

Another group of supervised health care personnel being charged high premiums is physicians' assistants. Even in jurisdictions where their ISO-published rates are the lowest, the cost of professional liability insurance for them is substantially higher than for most other supervised health care workers. A Duke University study found that most physicians' assistants are insured for their own professional liability through their employers, malpractice policies at about one-half the rate their supervising physicians pay for similar policy limits.[5]

One could speculate that the relatively high malpractice premiums charged physicians' assistants result from the more autonomous and responsible nature of their jobs compared to those of other supervised health professionals. Professional responsibility, however, does not appear to be the sole reason for the high rates. Nurse midwives perform tasks at close to the same level of responsibility as physicians' assistants, managing the care of mothers and babies throughout the maternity cycle so long as progress meets criteria accepted as normal. The midwives, however, pay much lower malpractice insurance rates. Members of the American College of Nurse Midwives, who are eligible for the inexpensive association malpractice insurance program, are registered nurses who have undergone additional, post-R.N. training. Their extensive schooling may have bearing on their low malpractice insurance rates. Probably more important, however, is the long history of their profession, compared to the newness of the physicians' assistant. Uncertainty about the malpractice exposure of physicians' assistants may well be the chief reason behind their high rates.

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[5] Duke University Medical Center, "Information Brochure", the American Academy of Physicians, p. 9.

In the past, the industrial nurse has been considered to be more vulnerable than other supervised health-care workers to being sued for malpractice in her own right. A worker who feels that he has suffered malpractice at a factory health-care unit is free to sue only the health-care personnel, not their employer. Application of the *respondeat superior* doctrine against the employer is precluded by workmen's compensation laws, which provide that a workman injured on the job must resolve his injury claim against his employer through the workman's compensation system rather than through litigation.

Malpractice insurance rates, however, do not reflect any particularly high malpractice risk for industrial nurses. Rates under the insurance program of the National Association of Industrial Nurses have, in fact, gone down in recent years. The association's current malpractice insurance rates are among the lowest for any allied health-care personnel.

"Named Insured" Endorsements

Special endorsements to hospital or other institutional policies which declare all employees to be "named insureds" are an alternative to individually purchased malpractice insurance for supervised health-care professionals as well as for interns, residents, and other autonomous health-care professionals who practice only as employees of the insured hospital or institution. Such endorsements provide for payment of legal fees as well as any awards or settlements that result from malpractice actions against the employees. They provide protection, however, only when the employee is acting within the scope of his employment at the insured institution. Suits or claims arising out of negligence alleged in a "Good Samaritan" situation, in a private practice situation, or in the scope of the insured's employment at another institution would not be covered.

Generally the "named insured" endorsements cost a hospital somewhere under an additional 25 percent of its regular malpractice insurance charge. No accurate estimate of what percentage of hospitals use the "named insured" endorsement for their employees is available at this time. A number of "guesses" have ranged around 50 percent. One large insurance broker reported that it recommends "named insured" coverage for employees to all its hospital clients and that about 90 percent of them purchase the coverage.

MEDIA AND MEDICAL MALPRACTICE

Michael Byrnes

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Introduction

The question of mass media effect on the medical malpractice phenomenon relates directly and indirectly to the causes and consequences of a nationally significant problem. A limited study undertaken to examine this question is reviewed in the following report.

The question of media effect is both complex and far-reaching and a definitive answer is clearly beyond the range of the present study. Conclusions and recommendations of the study are founded upon both subjective and objective factors. Statistics, examples, and trends, obtained primarily through a Nationwide survey of press and periodical clippings covering a twelve-month period (September 1971-August 1972), and interviews with representatives of the press, electronic media, and wire services, form the basis of the study.

To the extent that the study did not attempt to measure the reaction of the general public, it is limited. A particular newspaper story obviously affects individuals differently. The impact of a given story on a given individual can only be speculative. In the absence of a controlled statistical study, media impact on mass audiences is not measurable.

On the basis of the limited study undertaken, four tentative conclusions have been drawn:

(1) despite isolated instances of emotionalism, bias, and inaccuracy, press, radio, and television coverage of medical malpractice cases and problems is, on the whole, straightforward, factual, and balanced;

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(2) there is a clear and freely admitted lack of knowledge among members of the working press and electronic media of the complexities associated with the medical malpractice area and an expressed belief among them that an even greater ignorance of the subject exists within their audiences;

(3) despite the professed belief among many reporters that the malpractice area is too technical for adequate popular treatment, the daily press is nevertheless becoming more sensitive to the significance of the subject and is reflecting this awareness in an increasing number of editorial comments: and

(4) there is a growing recognition among professionals, newsmen, and the general public that the mass media, particularly television, by portraying medical "miracles" and failing to properly inform audiences of ever-present limitations, raised expectations that the medical profession can cure everyone.

With the foregoing tentative conclusions as perspective, a discussion of a press clipping survey, summary of media coverage at six of seven public hearings conducted by the Commission, and interview results of selected newspaper reporters and correspondents follow.

The Working Press and Malpractice

Between September 1971 and August 1972, more than 1600 separate news items directly related to medical malpractice and published in the daily, trade, medical, and professional press were assembled by the Commission. The clips were obtained through the services of a national clipping organization and represent Nationwide surveillance. A significant number of the items were categorized as major periodical stories, letters to the editor, editorials, or news stories based exclusively on the Commission hearings.

In order to maximize control and insure accuracy, the survey was limited to an analysis of some 1,200 clippings taken from the daily, trade and professional press. The breakdown is as follows:

Daily press news stories	751
Daily press feature stories	73
Trade and professional news articles	400

The Daily Press

Of 751 "straight" news stories which related to medical malpractice, 612 dealt with malpractice suits (filing of claims, prosecution of cases, jury awards, verdicts).

The remaining 139 stories taken from daily newspapers throughout the country dealt with various aspects of the malpractice problem and were usually pegged to statements made by locally or nationally well-known individuals either at well-publicized professional meetings or on the release of significant, malpractice-associated findings by national organizations. The majority of these stories dealt with allegations that the increase in medical malpractice suits had resulted in higher medical care costs or higher medical insurance or medical malpractice premium costs. Several stories discussed innovations in court procedure with respect to the handling of malpractice cases.

Only 7 of a total of 751 news clippings examined contained headlines or stories that could objectively be termed "emotional," biased, or sensational. Two examples of poorly worded headlines are: "Son Just A Vegetable, Mom Sues Hospital," and "Dying Youth Fights Parents." These headlines, while possibly sensational, are in no way persuasive.

Analysis of 612 stories based exclusively on circumstances surrounding the filing, prosecution, or conduct of a malpractice suit, revealed a direct relationship between the frequency of appearance of a particular story in multiple newspapers and its human interest content.

In this connection, to be objective, it might be said that "sensation" value clearly determined the size of the single news item which appeared with the greatest frequency. That story, based on the trial of an Illinois physician accused of drugging and sexually assaulting a former model (suing both criminally and civilly) appeared a total of 20 times over a six-month period in several Illinois newspapers.

The single story having the second highest frequency of appearance (six) concerned a physician, formerly a Cuban national, accused of fraudulently practicing medicine in an Illinois State hospital using as credentials a forged medical diploma.

The story ranking third in the number of mentions in different newspapers among the malpractice case categories concerned a youth with terminal cancer prosecuting a suit against his parents for control of a sum of money awarded as a result of a successfully concluded malpractice case.

Feature Stories

Of 73 feature stories assembled over the 12-month period, the majority dealt with the costs of medical malpractice. Although the significance of new medical techniques and procedures calling for upgraded continuing education for physicians was brought to the reader's attention in many of these articles, most were highly sympathetic of the "plight" of physicians confronted with a malpractice "syndrome", "wave", or "crisis".

The two largest feature articles, both series-types appearing in the Atlanta *Constitution* and the Tampa *Times*, were well-balanced, informative, and factual. The remainder were one-time pieces dealing with specifics of the malpractice problem, such as a *Wall Street Journal* story on emergency room care and a *National Observer* story on the feasibility of arbitrating malpractice suits.

Periodical Stories

None of the major national news periodicals during the 12-month period covered by the survey carried stories on the subject of medical malpractice. The absence of national periodical coverage is significant in that it indicates an obvious lack of interest in the subject both by periodical news editors and news magazine correspondents alike. It also indicates a general apathy toward malpractice among a mass periodical reader audience.

Trade and "popular" medical periodicals published 20 significant stories related directly or indirectly to malpractice. Many medical periodical stories were designed to help educate the physician-paramedical reader about ways to avoid malpractice suits. Others dealt with malpractice insurance matters and virtually all made mention of costs. *Medical Economics* carried the greatest number of malpractice articles.

Editorials

A total of 25 editorials concerning medical malpractice were assembled over the period surveyed. Frequently these were headlined, "The Malpractice Mess", "The Malpractice Crisis", or "The Malpractice Boom". Two contained the identical headings, "Why So Many Malpractice Suits?" Most editorials reflected at least some understanding of the causes of the malpractice problem, recommending better medical service, greater responsibility on the part of the physician, and more understanding and forbearance on the part of the patients.

Trade and Professional Press

The 400 clippings assembled from the legal, medical, drug manufacturing, and insurance news organs, tended generally to reflect in story content the interest of the profession or industry represented. The legal press showed by far the greatest understanding of the problem and, for the most part, was highly objective in reporting significant aspects of the malpractice phenomenon.

Summary of the Print-Media Survey

The survey of newspaper, periodical, and professional press articles on medical malpractice was intended to determine the frequency, display nature, type and content of print-media coverage dedicated to medical malpractice over a given time span. It was designed to be objective and sought some measurement of tone. Content analysis techniques of this type are inherently limited. They cannot measure emotional impact of a particular story and by themselves provide no basis for conclusions concerning the accuracy of what is reported.

The single characteristic common to virtually all of the material covered in the survey was the predominance of balanced, straight-forward reporting and the absence of "emotionalism" from story content.

Additional, well-controlled studies employing punch-card and computer techniques would certainly elicit important information related to the impact of news stories on medical malpractice and the effect, if any, these stories have on the malpractice problem.

Media Coverage of the Commission Hearings

Between October 1971 and April 1972 the Commission held seven public hearings in six widely separated cities around the country. Two hearings were conducted in Washington, D.C. Only the first of these will be treated here. The type and quality of hearing coverage varied markedly from city to city according to local *attitudes* on the significance of the malpractice problem.

Rating hearing coverage on a scale of poor, fair, good, and excellent, Los Angeles, which can be considered the geographical focal point (together with Southern California) of the malpractice problem, rated as a hearing site, only fair press coverage but good television coverage.

The Cincinnati hearing was accorded excellent press as well as Radio-TV coverage.

The third hearing, which took place in Washington, drew the largest number of reporters but was given surprisingly small space in the city's newspapers. The Washington hearing, however, because it included testimony from a representative of the Center for the Study of Responsive Law, received greater mention in national newspapers than any Commission hearing. That fact is accounted for by the filing of a story on the testimony by an Associated Press correspondent who covered the hearing. The story was carried the same night by the "CBS Evening News" (the only reference to the Commission's hearings on national network television).

The New Orleans hearing received fair newspaper coverage announcing the hearing, but poor coverage of the hearing itself. Radio-TV coverage was non-existent. The lack of interest in the New Orleans hearing by news media representatives matched the general absence of interest in medical malpractice in the city and apparently in the State. Evidence was abundant that Louisiana has no significant malpractice problem. In New Orleans, for example, only 15 witnesses testified before the Commission, while the hearings in Los Angeles and Cincinnati drew 42 and 52 witnesses respectively.

The Commission's New York hearing, like the Cincinnati session, was given extraordinary media coverage. It was possible in New York to monitor, through a commercial surveillance organization, most of the mentions made of the hearing on local radio and television stations. In a two-day period, the hearing was mentioned on five radio news broadcasts and on four television news programs. WCBS-TV gave the session a seven-minute segment on the "Ten O'Clock News," February 25, 1972.

Newspaper coverage of the New York hearing was also excellent and included a lengthy story on the hearing in the New York *Times*, one of the two occasions when the Commission achieved national press attention (the other was due to the Associated Press story out of Washington).

News story content again reflected media interest in either the prominence of the witness or the human element in given testimony, and was not a function of the malpractice issue itself. Greatest media attention was focused on the testimony of the parents of an infant who died in New Jersey allegedly as the result of improper medical diagnosis.

The Commission's final hearing in Denver received excellent newspaper coverage and consequently, as the result of two 30-minute television interview stories, good television coverage as well. Here again the press focused on human interest elements with major emphasis being placed, not on medical malpractice *per se*, but on the request of some prisoners at the Colorado State Penitentiary to testify at the hearing.

Conclusions About Media Hearing Coverage

1. A general indifference characterized the attitude of news media representatives toward the problem of medical malpractice.
2. Coverage provided the hearings was generally motivated by the feeling among most editors contacted by Commission staff representatives that there was a civic duty to give at least some attention to a problem that affected not just professional people but the general public as well.
3. The quantity of television footage and amount of space in newspapers given the hearings was a function of either the degree of human interest discerned by reporters in particular testimony or associated with the relative fame of the witness testifying. Space and footage were not, however, related to the belief among reporters or editors that the malpractice problem was of significance in and of itself.

Attitudes of News Media Representatives Toward the Medical Malpractice Problem

The media survey included, in its final phase, interviews with selected newspaper science writers, wire service correspondents, feature writers, and radio-television correspondents. Each was asked the following questions:

1. How would you characterize the medical malpractice problem from a professional viewpoint?
2. What factors do you feel inhibit reporting on medical malpractice issues?
3. How would you assign relative prominence to the various elements of a malpractice news story?

In answering these questions, each person interviewed stated that the medical malpractice area was "complex."

One reporter who had recently completed a four-part series for the Atlanta *Constitution*, said, "there is a general lack of adequate knowledge of legal concepts and principles among most reporters on the malpractice subject." He added that he had encountered difficulty in gathering material for the series because "it is hard to get people to be quoted." One insurance executive told him that ". . .the best thing to do would be not to write anything at all on the subject."

One well-known Long Island reporter covering the science-health field for an important regional daily provided the most cogent responses to the questions asked. "Professional people," he said, "are interested (in malpractice) but the public generally is not. This area is too technical for both the average reporter or layman to adequately grasp. There is, however, human interest in large settlements."

When asked if he felt that popular television programs could, in any way, be related to the increase in malpractice suits, he replied that TV programs, "like Marcus Welby certainly would have an effect on many viewers. They would attempt to identify with the victim or compare their own experiences with those of the patient."

Another reporter covering science for a Boston daily agreed with a Washington United Press International correspondent that malpractice stories provide little, if any, feed-back. The United Press International correspondent added that the subject was "dull" and that "it had not yet surfaced as a major news issue." He compared the Malpractice Commission study with the Marijuana Commission investigation, pointing out that the *report itself* gave the problem important news value. He concluded that the Malpractice Commission report might result in the "surfacing" of malpractice as a newsworthy subject for the general press.

Nearly all of the reporters interviewed agreed that human interest content (i.e., large settlements) gave any malpractice story its principal value. All said that malpractice did not rank as a major issue in today's world beside matters such as pollution, the economy, the Indo-China War, urban decay, and social justice.

Mass Media and the General Public

There is general agreement among experts interested in the malpractice problem that popular television has conveyed to millions of Americans a distorted picture of the capabilities of modern medicine without also identifying its limitations. The effect of many medical TV programs portraying the achievement of miraculous results is to raise expectations that the medical profession can cure anything. Agreement is also widespread among many professionals that this recurring theme has indeed had an impact on the rise in medical malpractice claims.

It is beyond the scope or capacity of the survey to measure the impact of television viewing on mass audiences. However, we do recommend further study of the problem under controlled conditions. A survey of selected households, or of plaintiffs who have brought malpractice suits, might well provide some valuable insights with respect to the effect of popular medical TV programs on the general public.

CONSUMERS' KNOWLEDGE OF AND ATTITUDES TOWARD MEDICAL MALPRACTICE

James L. Peterson, Ph.D.

Summary

The objective of the study on which this report is based was to describe the attitudes, level of knowledge, and involvement of the public with the medical malpractice problem.

The report is based on an interview study of a sample of household heads and spouses. The sample was drawn on an area probability basis to be representative of the population of household heads and spouses in the continental United States. Data were collected during hour long personal interviews with 1,017 respondents. In the following summary the major descriptive and associated results are presented in outline form.

The major descriptive results may be summarized as follows:

1. The sample distributions of demographic variables approximated rather closely those 1970 census distributions which were available for the same population. It may be concluded that the sample adequately represents the target population.
2. While a fairly solid base of information about certain aspects of medical malpractice existed among the sample, few could be characterized as being highly informed about the problem, as shown in many of the following summary statements.
3. The average time thought to be required to win a malpractice suit was about 31 months: the median percentage thought to win suits was 10%. The first of these perceptions is fairly accurate, but the second is a serious underestimate.
4. The median sample estimate of the number of physicians sued each year for malpractice in the United States was 5%, while the actual figure is 2%.
5. About half the population was aware of the contingency fee method of paying for lawyer's fees in a malpractice case.
6. About half the population was aware that doctors can obtain medical malpractice insurance.
7. When asked to define medical malpractice, about one-fifth said they do not know and about one-half gave a response containing the idea of negligence only. Very few gave a substantially correct definition linking negligence as a proximate cause of damage.
8. More people felt that the amount of malpractice and the number of malpractice suits are increasing than felt they are decreasing; this tendency was most pronounced for the latter of these two variables—the number of malpractice suits.

9. In the area of attitudes, most people felt the doctor-patient relationships today were not as good as they were about 20 years ago; technical competence of doctors however, was viewed as virtually unchanged.
10. More people felt that dedication to work of doctors has declined than felt it has increased over the last generation. Even more, however, felt that the dedication to work of people in general has declined, so that doctors were viewed relatively more favorably on this dimension.
11. Over two-thirds of the respondents felt that the medical profession does an adequate job of regulating the practices of its own members. About one-fifth felt it does not; the others said they did not know.
12. Just over two-fifths of the respondents reported that they, their spouses, or a dependent had a

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negative medical care experience. Very few reported more than three such incidents.

13. Looking only at those respondents describing negative medical care experiences, most of these respondents felt there had been some kind of failure or negligence on the part of the doctors involved. The most frequently perceived failures involved errors of judgment, of which "failure to diagnose correctly" was most often mentioned.
14. Physical injuries were perceived by a relatively small proportion of those reporting negative care experiences: about 18% and 13% felt negative medical care had resulted in a disability, or in unnecessary damage to appearance, respectively.
15. Two-thirds felt they had suffered economic damages because of the experience. Most of these felt the loss was attributable to additional medical expenses.
16. Four-fifths of the respondents felt that the experience had caused unnecessary pain and suffering.
17. Of those with negative experiences, almost two-thirds sought additional medical care afterwards. About half of those who did not seek additional care report that they did not do so because they felt additional care could not restore their health.
18. Only 8% of those with negative medical care experiences considered seeking the advice of a lawyer. Of these less than half actually did talk to a lawyer.

The associational results may be summarized as follows:

1. Statistically significant associations were found between the number of reported negative medical care experiences and the major demographic variables: marital status, age, religion, education, occupational status, income, age, and geographic mobility. The only exceptions were race and sex. It was suggested that many of these associations might be accounted for either directly or indirectly by social status—the higher the status, the more incidents reported. Among many alternative explanations of this relationship, one suggested possibility was the operation of a form of deference—that is, the greater the social distance from the doctor, the more likely one may be to defer to the authority and status of the doctor in interpreting causes of negative outcomes.

2. Negative attitudes towards doctors were significantly associated with number of reported incidents. For example, those who felt the doctor-patient relationship of today's doctors was poor, or who felt it has deteriorated tended to report more incidents. The same was true for those who felt doctors' dedication to work has declined and those who felt the amount of malpractice has been increasing in the last few years. It was suggested that the direction of causation in this association was undeterminable from survey data and that attitudes and perceptions of experiences might well be mutually reinforcing.
3. A scale measuring the intolerance of ambiguity was included in the questionnaire. Those scoring as highly intolerant of ambiguity on this scale tended to report fewer incidents. Tentative explanations were offered in terms of attitude consistency hypotheses.
4. More incidents were reported by those more exposed to the risk of a negative experience—that is, those with more health care experiences.

5. The amount and severity of damages and injury, as measured by several variables, was strongly related to considering seeking legal advice after the negative medical care experience.
6. The amount of exposure to the legal system was likewise related to considering seeking legal advice, especially when that exposure involved previous experience with suing.
7. In general, other characteristics of the negative medical care experience (such as initial type of illness or condition, type of treatment involved, and specialty of physician with the possible exception of surgeons) were not related to considering seeking legal advice.
8. Specific knowledge about malpractice was not significantly related to considering seeking legal advice.
9. Among the demographic variables, only race was significantly related to legal response, with blacks more likely to consider seeking legal advice than non-blacks.

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I. Introduction

The purposes of the present study are to describe and explain the consumer's attitudes toward, knowledge of, and involvement with medical malpractice. The study seeks answers to a wide range of questions, including the following: What proportion of the incidents in which consumers feel they have received damaging medical care come to the attention of the legal community? What kinds of responses do people make when they feel they have received inadequate or damaging medical care, and what factors explain the kind of response made? How much do people know about medical malpractice, and how is this related to their perceptions of the medical care they receive and to their responses to perceived poor medical care? What attitudes do people hold toward the medical profession and how are these attitudes related to their perceptions of the quality of the care they receive and to their knowledge of medical practice?

II. Methodology

A. RESEARCH DESIGN

The data included in this report were derived from 1,017 personal interviews conducted with heads of household, or spouses of heads of household. Households were selected on the basis of an area probability sample to be representative of the national population of households in the continental United States.[1] Each of these interviews was approximately one hour in duration. The content and format of the questionnaire utilized were based on the results of two "In-Group" discussions, during which videotape recordings were made of groups of eight and seven people, respectively, as they discussed the issue of medical malpractice under the direction of a group moderator. Participants were solicited from the Philadelphia area by telephone or personal call, and were screened so that each had had at least one negative medical care experience. Though not a representative sample, they did vary on major demographic variables such as age, race, sex, and social status. The moderator used a discussion guide to insure that the discussions covered the topics of primary relevance to the study. The responses of participants enabled the study direction staff to design a questionnaire emphasizing those topics perceived as important, as well as to word the questions to be readily understandable by respondents. The topics outlined in the discussion guide used by the group moderator, as well as those questions included in the final instrument, were based in part on a review of the malpractice literature. They were also based to some extent on a review of the testimony collected during public hearings of the Secretary's Commission on Medical Malpractice, and on consultation with the Commissions's research staff.

The final format of the questionnaire was guided by the results of an administrative pretest, during which not only the subjects' responses, but also their reactions to the survey instrument were considered. Two versions of the instrument were utilized at the pretest stage to test alternative wordings for key question; nine subjects were interviewed for each version.[2]

B. QUESTIONNAIRE TOPICS

Based on the consideration of the literature review, the In-Group discussions, the administrative pretest, and most importantly ISR's understanding of the goals of the Commission, the following topical areas were included in the questionnaire:

1. Knowledge

It was felt that a major underlying cause of the malpractice phenomenon might be the public's general misunderstanding of legal and other attendant concepts. Thus, questions relating to definitions of malpractice, awareness of malpractice insurance and other measures of knowledge related to malpractice, constituted an important part of the research instrument.

2. Attitudes

Questions tapping attitudes toward medical malpractice and toward doctors[3] in general were included, since it was felt likely that such attitudes would be related to perceptions of and reactions to medical care experiences.

3. Demographics

Traditional demographic information items (such as age, sex, religion, socioeconomic status, etc.) were included.

4. Exposure

Since it was expected that knowledge and attitudes related to medical malpractice would be related to experience with the medical and legal communities, several questions were included which measured this exposure.

5. Perceived Incident Involving Negative Medical Care

A major item in the questionnaire was designed to discover whether the respondent, or one of his or her dependents, had ever experienced an incident involving negative medical care. If so, both factual and subjective questions were utilized to obtain a detailed account of one such occurrence.

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[1] A detailed description of the sampling procedure and an evaluation of the coverage and response rate may be found in the Appendix.

[2] The discussion guide, and the final version of the questionnaire may be found in the Appendix.

[3] As used in this study, the word "doctor" refers to any health care professional having a doctor's degree. Thus it includes not only medical doctors, but also dentists, osteopaths, clinical psychologists, and so on.

C. DATA COLLECTION AND REDUCTION

1. Interviewer Selection and Training

Interviewers who had previously worked in the listing areas selected for this study were sent availability notices. Other interviewers were hired through applicants in our file. In addition, six were hired through newspaper advertisements. In all, 68 interviewers were employed in the study.

Four regional training conferences, each lasting two days, were held toward the end of September, 1972. A manual of general interviewing techniques was prepared and mailed to each interviewer prior to the training conferences. At the conferences, interviewers were given intensive training on listing, screening, and the questionnaire. A practice interview was completed by each interviewer at the training conference. The trainer reviewed each questionnaire with the interviewer, devoting special attention to weaknesses encountered. No interviewer was allowed to proceed without completing a satisfactory practice interview.

2. Screening Forms

In households containing both a household head and a wife of head, the research design called for randomly selecting the head or the wife as the respondent. This was accomplished by using two different colors on screening forms. Each even numbered housing unit was assigned a blue form; each odd numbered housing unit, a pink form. The head of the household was the selected respondent on the blue screening form, regardless of whether there was a wife of head or not. On the pink form, the wife of the head was selected respondent if there was a wife; otherwise, the head was the selected respondent.

3. Validation

A validation procedure was used to insure that interviews were actually completed, were done in person, and were done with the correct respondent. As each interview came into the office, a letter was sent to the respondent asking confirmation that the interview was conducted and repeating a few selected questions from the questionnaire, so that comparisons of responses could be made. Almost 55% of the validation letters were returned. Telephone validations were also conducted with a sample of respondents who had not answered the mailed validation letter. Each interviewer had at least 20% of her work validated.

As a result of the validation procedures, it was found that one interviewer had falsified her work. All of her interviews were discarded. No other invalid interviews were detected.

4. Editing

Each interview was edited for completeness and accuracy of following skip instructions. If any errors or omissions were discovered, a copy of the relevant question(s) was sent back to the interviewer for correction.

5. Coding and Keypunching

Each interview was coded by two separate coders working independently. Discrepancies were resolved with the coding supervisor. A special group of coders was trained by the study director to code the open-ended questions. These questions were also double-coded and discrepancies resolved by the supervisor. The coded interview schedules were then keypunched and verified.

6. Data Cleaning

The punched data were then subjected to computer cleaning routines designed to detect invalid and inconsistent codes. All such errors were corrected and the data were resubjected to the cleaning routines until no more errors were found.

III. Results

A. INTRODUCTION

The results can be divided into two broad types: descriptive and associational. The descriptive results consist of the distribution of the sample population on a number of variables of major concern for this study: knowledge of malpractice, attitudes toward the medical profession, the number and nature of negative medical care experiences, "and the type of response made by persons to such experiences. The association results concern the relationship between variables. For example, these findings identify the characteristics of persons who report more negative medical care experiences, the types of experiences which are more likely to lead to legal and other responses, and so on. We turn first to a discussion of the descriptive findings.

B. DESCRIPTIVE RESULTS

1. Demographic Description of the Sample Population

The population of this study was defined as the population of household heads and spouses in the continental United States. This population differs slightly in its demographic characteristics from the general population which includes other household members as well, chiefly children. A demographic description of the sample population is therefore important to provide the context in which to view other study data.

Sex—in each selected household, the head of household was determined. If the head was married, either the head or spouse was randomly selected to be interviewed, with equal probability; otherwise, the head was interviewed.

The percentages of male and female respondents obtained were 41.9% and 58.1%, respectively. These figures differ slightly from the corresponding U.S. Census estimates of 44.2% and 55.8%, respectively. The slight oversample of females may be explained by a higher rate of refusal and nonresponse by males, and by sampling variation.

Age—When ages are grouped in 5- and 10-year intervals, the distribution shows a decline in the percentage in each category as age increases, as one would expect. The first category, age 24 or less, is small, however, reflecting the small number of households headed by persons younger than 24. The distribution is given in Table 1 along with comparable U.S. Census figures. The underrepresentation of older persons (and hence overrepresentation of younger persons) in the sample may stem from the higher refusal rates of older persons, a phenomenon common to most sample survey studies.[4]

Education—Respondents were asked the last grade in school which they completed. For all but the youngest respondents, who may still have been in school, this variable represents final educational attainment. As can be seen in Table 1b, nearly two-thirds of the sample are at least high school graduates, and over one-third have had at least some college education. Comparable figures from the Census are not available.

Income—Table 1c shows family income before taxes expected in 1972. The distribution is quite similar to that given by the Census.

Occupation—The occupational distribution of the principal wage earners in the sample households, who are not necessarily the respondents themselves, is given in Table 1d. The relatively high percentage of persons not employed may be accounted for by the inclusion in the sample of retired individuals (16.2% of the respondents were age 65 or more).

Religion—The sample distribution of religious preference is given in Table 1e. The U.S. Census does not collect data on religion for comparison, but the figures do agree closely with those obtained from previous national studies at ISR.

Race—The racial distribution of the household heads is presented in Table 1f. This variable was coded by the interviewer by observation. No attempt was made to separately classify Americans of Spanish descent because of the difficulty of doing this by observation. These individuals are distributed among the black, white, and "other" categories. Likewise, American Indians are likely to be found in the black, white, and "other" categories. These factors, a slightly higher refusal rate among whites and sampling variation may account for the slight overrepresentation of blacks in the sample.

In summarizing the demographic description of the population presented in this section, it seems that available Census data and data from the present sample are quite similar. In those cases where Census data are not available, the distributions conform closely to those found in other national surveys carried out at ISR. Such variations as exist are, for the most part, those often encountered in sample surveys such as a slight overrepresentation of females and of younger persons. Other derivations are within the expected range of sampling error. In all, it may be concluded that the sample is indeed representative of the target population.

2. Knowledge of the Medical Malpractice Problem

One of the primary aims of this study is the determination of the public's perceptions of the medical malpractice problem, for it is these perceptions—whether correct or not—which, together with attitudes, largely determine behavior following negative medical care experiences.

A key question is how consumers define medical malpractice, compared to a legal definition. A thorough and correct definition would be lengthy and difficult to present because of the fine points of law and argument over interpretation of the concepts involved, not to mention the problem of legal variation in the definition from place to place. Nevertheless, a generalized definition may be given which captures the essence of the phenomenon: medical malpractice may be said to have occurred if each of the following conditions obtain a) a patient-provider relationship exists, b) the provider is negligent in providing health care, c) damage,[5] whether mental, physical, or economic, is inflicted on the patient, and d) the negligence is the proximate cause of the damage.

To gather information on how the public defines malpractice, respondents were asked: "In general, what do you think medical malpractice is?" In response, most respondents mentioned at least one of the above points, although very few demonstrated a complete understanding of the concept. As seen in Table 2, 19.8% stated that they did not know[6]; 44.5% gave a definition involving only the element of negligence; 0.6%, involving only damage; and 4.2%, involving both damage and negligence, but not linked by proximate cause. Only 5.0% gave a definition which was substantially correct, causally linking negligence to damage. As for the remainder, 2.8% gave a completely incorrect definition, and 22.9% gave specific examples instead of a definition (over two-thirds of these examples dealt only with negligence).

Thus, a substantial proportion of respondents (one-fifth) say they do not know what medical malpractice is. This may, of course, be an underestimate of those not knowing, since some respondents may be unwilling to admit igno-

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[4] See, for example, Leslie Kish, *Survey Sampling* (New York: John Wiley & Sons, Inc.), 1965, p. 537.

[5] As used in this report, "damage" refers to any kind of mental or physical harm or injury, and to any kind of economic cost or loss.

[6] When asked a question of fact, many respondents who do not know the answer may, nevertheless, give a response to the interviewer rather than say they do not know and thus appear to be uninformed. In spite of this tendency, substantial proportions (ranging from about 10% to 20% on these questions discussed in this section) do state directly that they do not know the answer.

TABLE 1

SAMPLE DISTRIBUTION ON SELECTED DEMOGRAPHIC CHARACTERISTICS AND COMPARABLE 1970 U.S. CENSUS FIGURES, WHERE AVAILABLE

Category	Percent*	
	Sample N = 1017**	U.S. Census
a. *Age*		
0 - 24	9.5	7.3
25 - 29	12.6	9.6
30 - 34	11.5	8.8
35 - 44	17.0	18.2
45 - 54	17.8	19.4
55 - 64	15.2	17.0
65 - 74	10.4	12.0
75 or more	5.8	7.6
Total	100.0	100.0
b. *Years of Schooling Completed*		
0 - 8	17.5	Not Available
9 - 11	18.0	
12 (High School Graduate	29.5	
1 to 3 years of college	18.5	
4 years of college	8.8	
More than 4 years of college	7.8	
Total	100.0	
c. *Expected Family Income before Taxes, 1972*		
Under $2,000	4.2	4.6
$2,000 - $3,999	10.2	9.4
$4,000 - $5,999	13.0	11.1
$6,000 - $7,999	13.2	12.3
$8,000 - $9,999	13.9	13.6
$10,000 - $11,999	10.3	12.7
$12,000 - $14,999	14.0	14.1
$15,000 or more	21.1	22.3
Total	100.0	100.0

TABLE 1 (Cont'd.)

Category	Percent*		
	Sample		U.S. Census
d. Occupation of Principal Wage Earner			Not Available
White Collar		37.3	
Upper (Professionals, managers, proprietors)	26.0		
Lower (Sales, clerical)	11.3		
Blue Collar		40.2	
Skilled (Craftsmen)	14.7		
Semi-skilled (Operatives)	12.9		
Unskilled (Laborers, except farm)	12.6		
Farmers and Farm Laborers		1.6	
Armed Forces		1.8	
Unemployed or Not in Labor Force		19.2	
Total		100.0	
e. Religious Preference			Not Available
Protestant		71.4	
Catholic		19.2	
Jew		2.2	
Other		1.1	
None		6.1	
Total		100.0	
f. Race			
White		86.6	89.4
Black		12.1	9.6
Other		1.3	1.0
Total		100.0	100.0

*Percents in this and all following tables may not add to 100.0 due to error introduced by rounding. Whenever the 100 percent figure is used, it indicates mutually exclusive and exhaustive categories accounting for the entire N in the table.

**The letter N in this and all subsequent tables refers to the number, N, of respondents upon which the percentages are based.

rance to an interviewer on a factual question. Of those who do offer a definition or example, by far the majority give a definition or example involving only negligence. Respondents were not asked to define negligence; however, from a study of the responses given to the question on the definition of malpractice, it would appear that the public's definition of this concept is not narrow. Thus we may conclude that much of the public may be ready to label a wider variety of experiences as malpractice than would actually warrant that designation.

More respondents felt that the amount of medical malpractice had been increasing than felt it had been descreasing in the last five years (34.1% and 14.4%, respectively), while 35.3% felt the amount had remained the same. The reminder (16.2%) said they did not know.

In a pair of related questions, respondents were asked what percentage of physicians they thought were sued in the past year and whether they thought that this percentage had increased, remained the same, or decreased in the last five years. In response to the first question, 14.2% said they did not know; for those giving a percentage, the quartiles of the distribution were as follows: the lowest quarter said 3% or less; the next quarter, 3 to 5%; the third quarter, 5 to 15%; and the highest quarter, 15% or more. The actual proportion of physicians who had claims brought against them in 1971 is approximately 2%. Thus, most of the respondents were fairly accurate—about half were within three percentage points. Most of the error, however, was in the direction of overestimating the number. At the same time, over half (54.1%) felt that this

TABLE 2
RESPONSES TO THE QUESTION "IN GENERAL, WHAT DO YOU THINK MEDICAL MALPRACTICE IS?"

Response	Percent (N = 1015)
Don't know	19.8
Example only given	22.9
Definition given	
Completely incorrect	2.8
Definition included negligence only	44.5
Definition included damage only	.6
Definition included damage and negligence, but not causally linked	4.2
Definition substantially correct, including damage caused by negligence	5.0
Total	100.0

percentage had increased over the last five years, 27.4% felt it had remained the same, and only 7.9% said it had decreased; the rest (10.2%) said they did not know.

The following observations should be borne in mind when interpreting the results of the previous paragraph. First, past surveys indicate that when asked for a numerical estimate respondents tend to give answers which are divisible by 5. This was true in the present study in which we found large proportions of the respondents indicating 5%, 10%, 15%, and so on. Second, since no estimate can be lower than 0%, and since the correct answer in this case is 2%, most errors are likely to be in the direction of overestimation. Finally, although many respondents overestimated the proportion of doctors sued, most gave responses indicating a realization that the proportion was small.

It would appear that the public views the problem as being somewhat more prevalent than it is (most overestimate the percentage of doctors sued) and that they tend to favor the view that it is increasing rather than decreasing. On this question, it is of significance to note that more feel that the amount of actual malpractice is increasing. Thus, it may be that the public is actually aware of its own increased litigiousness with respect to medical care.

Although over half of the respondents (53.3%) were aware that doctors could obtain malpractice insurance, nevertheless, large proportions either did not know such insurance was available (36.1%) or thought that it definitely was not available (10.5%).

Respondents were also asked questions about malpractice suits and their consequences. It has been suggested that one factor deterring many people from initiating a suit is their belief that they would have to bear the cost of a suit which fails. Respondents were asked, therefore, about how the legal fee for a malpractice suit is determined. The population is about equally divided between those who thought they would have to pay something regardless of the outcome, and those who thought they would have to pay only if some money were awarded. The results are presented in Table 3.

TABLE 3

SAMPLE DISTRIBUTION ON TYPE OF LEGAL FEE THOUGHT TO BE CHARGED IN A MALPRACTICE CASE

If you went to a lawyer about a malpractice suit, do you think he would charge:	Percent (N = 1,010)
A fixed amount	12.3
A percentage of any money awarded	47.3
A fixed amount plus a percentage of any money awarded	30.5
An hourly rate	4.2
Don't know	5.7
Total	100.0

Perhaps of more crucial importance than perceived type of legal fee in influencing behavior is perception of the effort and chances of success involved in bringing a malpractice suit. Respondents were asked: "Of those who bring a medical malpractice suit against a doctor, about what percentage do you think get money?" To this question, 12.5% said they did not know; but among those giving an answer, the median percentage thought to succeed was 10%. This extremely low estimate has great potential significance for behavior. It is reasonable to hypothesize that persons believing the chances of success in a suit are extremely remote are unlikely to attempt this form of action.

Respondents were then asked: "About how long do you think it takes to get money from a malpractice suit?" About the same proportion, 12.1%, said they did not know; but for those giving an answer, the average length of time reported was just over 31 months. This perception, which is fairly accurate, also may be a potential barrier to choosing legal action when a person feels he has been a victim of medical malpractice.

One final area of perceptions needs to be explored: what do people believe happens to a physician who loses a malpractice suit? The most prevalent responses to this question are those that indicate the physician is likely to be harmed—i.e., he will lose his license or practice, he will lose money, or his reputation will be damaged (see Table 4). The loss of license is not at all likely to happen in fact. But again, the public's belief that it does may influence their decisions, one way or the other, about what to do when they believe themselves to be the victims of malpractice. The third most frequent response is that the physician loses money. The fact that this category is not larger may reflect the awareness by over half the sample that malpractice insurance is available to physicians.

TABLE 4

PERCENTAGES INDICATING
VARIOUS CONSEQUENCES TO A PHYSICIAN
RESULTING FROM THE LOSS
OF A MALPRACTICE SUIT
(MULTIPLE RESPONSES POSSIBLE)

Consequence	Percent (N = 1,014)
License Lost	47.8
Reputation Damaged	43.2
Money Lost	28.0
Malpractice Insurance Premiums Increased	8.6
Medical Practice Lost or Moved	7.1
Malpractice Insurance Lost	4.8
Jailed	2.6
Medical Practice Improved	0.9
Other	9.0
Nothing Happens	9.0
Don't Know	6.0

In summary, it would appear that the public is not highly informed on a variety of aspects related to the problem of medical malpractice. Few demonstrated a complete understanding of the concept of medical malpractice, many overestimated the percentage of doctors sued, many were unaware of the availability of malpractice insurance, about half were unaware of the contingency fee arrangement for paying lawyers, most thought the proportion of persons winning malpractice suits was extremely low, and about half thought that a doctor who lost a malpractice suit would lose his license as a result. Although not highly informed, a solid basis of information does nevertheless exist. Varying proportions ranging up to one half gave substantially correct responses to the above questions.

An attempt was made to evaluate potential sources of information on medical malpractice. Sixty-four percent of the respondents claim to have seen, heard, or read about a malpractice suit in the media—newspapers, magazines, radio, or television. In contrast, 6.4% say they personally know individuals who have seen a lawyer about making a medical malpractice claim, and 2.5% say they personally know someone who has received money after making such a claim. Among respondents themselves, 1.4% have seen a lawyer about making a malpractice claim. In comparing these latter sources of information with the first, it is evident that respondents are much more likely to have obtained information about malpractice from the media than from a personal knowledge of cases. However, it may be that information from the media, while reaching more people, is at the same time more superficial. The present data do not answer this question.

3. Attitudes Toward the Medical Profession

A second group of variables which may influence perceptions of the medical care received, and which may influence behavior in response to those perceptions, consists of the attitudes held toward medicine and the medical profession. It is important, therefore, to describe the range of attitudes reported by the respondents. In particular, it may be that one of the causes of the recent increase in medical malpractice suits is the deterioration of the doctor-patient relationship and the confidence which the consumer places in the medical profession. It is therefore important as a first step to determine whether such a deterioration is reflected in the survey responses.

An eight-item attitude scale was developed which was divided into two subscales: the first measuring characteristics of doctors thought to contribute to the doctor-patient relationship, and the second, characteristics thought to measure competence. Respondents were asked how well they felt each item described doctors on a four-point scale of very well (1), fairly well (2), not very well (3), and not at all (4). The items used were:

Doctor-patient relationship.

a) Personally interested in patients
b) Willing to make house calls
c) Honest
d) Spends enough time with each patient
e) Explains things so patients understand

Technical competence.

a) Competent and qualified
b) Effectively treats most illnesses and injuries
c) Usually discovers the cause of symptoms

A score for each subscale was calculated by summing the item responses and then dividing by the number of items. Scores thus ranged from 1.0 (very well) to 4.0 (not at all) for each subscale.

Respondents were asked to do the rating twice, one for "doctors in general about 20 years ago," and again for "doctors in general today." The phrase "about 20 years ago" was chosen to operationalize the notion of "a generation ago," so that all respondents had the same frame of reference. Responses to these ratings were then compared.[7]

The average attitude scores for these scales are presented in Table 5. The results lead to several conclusions. First, respondents rating doctors about 20 years ago view the doctor-patient relationship items and the technical competence items about equally favorably. Second, respondents view the doctor-patient relationship items of doctors today much less favorably than those of doctors 20 years ago (a significant difference of .77 in scores). Third, respondents view the technical competence items of doctors today about the same as those of doctors about 20 years ago (a nonsignificant difference in the opposite direction of .03 in scores). Thus respondents seemed clearly able to differentiate these two factors, seeing a great deal of change on one factor and little or no change on the other factor. It could be hypothesized that this perceived shift contributes to the increase in malpractice suits: a perceived decline of the doctor-patient relationship may weaken the barrier which a personal relationship presents to suing a doctor.

TABLE 5

SAMPLE AVERAGES ON ATTITUDE SCALE SCORES

Time Reference	Subscale	
	Doctor-Patient Relationship	Technical Competence
Doctors Today	2.25 (N = 977)	1.56 (N = 994)
Doctors 20 Years Ago	1.48 (N = 955)	1.59 (N = 972)
Differences	.77 ($p < .0001$)	-.03 ($p > .2$)

Respondents were also asked to compare the dedication to their work of today's doctors with doctors of a generation ago. A large proportion (44.3%) responded that there was no difference in dedication. But of the remaining respondents, more felt that dedication had decreased (35.1%) than felt that it had increased (19.0%); 1.6% gave no opinion.

Although this finding is interesting in itself, it is important to place it in perspective. Thus respondents were also asked a similar question about the dedication to work of "people in general" rather than doctors. The results indicate that most respondents feel the dedication to work of people in general has declined, and that this decline has been sharper for people in general than it has been for doctors specifically. As seen in Table 6, only 32.2% said there was no difference in dedication of people in general; 54.3% felt that dedication was less; and 11.8%, more. No opinion was given by 1.8%. It appears, then, that the tendency to view doctors' dedication as having declined is part of a stronger tendency to view the dedication of people in general as having declined. By comparison, doctors' dedication to work is thus regarded more favorably than the general population's dedication to work.

TABLE 6

DEDICATION TO WORK TODAY COMPARED WITH A GENERATION AGO, FOR DOCTORS AND FOR PEOPLE IN GENERAL

Dedication to Work	Percent	
	For Doctors (N = 1014)	For People in General (N = 1013)
Has increased	19.0	11.8
Has remained the same	44.3	32.2
Has decreased	35.1	54.3
Don't know	1.6	1.8
Total	100.0	100.0

Respondents who indicated that doctors today are either more or less dedicated than doctors a generation ago were asked why they felt that way. The responses given by this sample are presented in Table 7.

Not surprisingly, people are more articulate in their complaints than in their praise. It is significant to note that the most frequent category of complaint is "doctors are more impersonal or inconsiderate," the one category which comes closest to making a statement about the doctor-patient relationship; and the most frequent category of praise is "doctors know more, are better trained," a statement dealing directly with technical competence. Thus, the results of the attitude scale discussed earlier seem to be reflected in the response to this item. It is possible, of course, that answers to this question were stimulated by the items presented in the earlier attitude questions. That is, a "response set" may have influenced respondents to answer similarly to maintain consistency on

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[7] In asking respondents to rate doctors "about 20 years ago," it should be recognized that we are *not* attempting to approximate what those same respondents would have said had they been asked the question 20 years ago, nor what a random sample of respondents chosen and questioned 20 years ago would have said. Rather, we are measuring *current* attitudes towards "doctors about 20 years ago," recognizing that these attitudes have been formed and influenced by experiences occurring over a long period of time, up to and including the present. By comparing the two sets of responses, we are not necessarily measuring actual change in attitude, but perceived change in attitude. Actual change could be measured only by employing a longitudinal design. Nevertheless, it is argued here that it is a person's current perception of his attitude change rather than his actual change which may be most strongly related to current behavior.

TABLE 7

REASONS FOR OPINIONS AMONG SUBSAMPLE FEELING THAT DOCTORS ARE MORE OR LESS DEDICATED (MULTIPLE RESPONSES POSSIBLE)

Reasons for Feeling that Doctors are More or Less Dedicated	Percent (N = 546)
a. Less Dedicated	
Doctors are more interested in money	25.8
Doctors are less accommodating, more difficult to reach	23.1
Doctors are more impersonal or inconsiderate	36.1
Other reasons	8.8
b. More Dedicated	
Doctors know more, are better trained	23.7
Doctors have to work harder now	6.4
Doctors are more interested in medicine now	7.2
Other reasons	6.1

these two related attitude questions, or the previous question may have suggested answers which the respondents then gave to the second question.

One final attitude item, which may have some influence on the response made to unsatisfactory medical care, is how well the person feels the medical profession regulates the practices of its own members. In response to this question, 70.3% felt the profession does an adequate job of regulation, 21.4% felt it does not, and 7.8% said they did not know. To resolve the apparent discrepancy between perceived adequacy of regulation and perceived dedication to work requires going beyond the data. However, it is suggested here that respondents may view the job of regulation as involving maintenance of medical standards related to technical competence (which they apparently feel is adequate) and not to items related to dedication and doctor-patient relationship. If so, contrasting attitudes toward regulation and dedication could be held simultaneously.

In summary, the attitudes of the public towards the medical profession are characterized by a certain measure of ambivalence. On the one hand they view medical professionals as being as competent, as able to diagnose and treat disease, and as well trained as doctors 20 years ago. On the other hand, they feel that at the point of contact between the doctor and his patient, there has been a deterioration—the doctor is more impersonal, spends less time with his patient, does not explain things as well, is too busy and often difficult to reach.

4. Consumers' Negative Medical Care Experiences.

A major objective of this study was to determine the extent and nature of consumers' perceived negative medical care experiences. It is of primary importance to discover what proportion of the instances of perceived negative medical care come to the attention of the legal community. Are the cases which do come to the attention of lawyers the worst cases? Of the cases which do not come to the attention of the legal community, what proportion would appear to be serious enough to warrant legal attention, and what proportion are really just minor complaints?

Before attempting to answer these questions, it should be emphasized that throughout we are dealing with respondents' perceptions only. We have already seen that most people lack a detailed, complete understanding of what constitutes malpractice. We must also presume that most lack the medical sophistication required to know with relative certainty whether they have been negligently cared for. We are not, therefore, attempting to judge whether malpractice has indeed occurred in any of these cases. But what we can determine is whether respondents *perceive* that they have been negligently treated and damaged as a result. For the purposes of understanding behavior, perceptions may be more important in any case; one who has been treated adequately but who is dissatisfied with the care he has received may be much more likely to complain or see a lawyer than another who is entirely unaware of the negligent and damaging care he has received.

Perceptions of the negative medical care experience.

To determine whether the respondents perceived that medical care received by them, their spouses, or dependents involved a potential incident of malpractice, a series of four questions was first asked, each dealing with a slightly different aspect of what was called a "negative medical care experience." The first question focused on negligence; the second, medical damage; the third, economic damage; and the fourth, quality of care. A "negative medical care experience" was said to have occurred if the respondent answered "yes" to any one or more of these four questions.

There were two compelling reasons for structuring the question this way. First, a single question combining all the aspects covered in the four subquestions would be too long. It is well known in survey interviewing that questions which are too long or contain too many ideas will not be understood or remembered in their entirety by many respondents. In answering such questions, they may respond only to that phrase in the question which they best understand or remember. Second, our experience during the pretest and questionnaire development indicated that many people who had genuine negative medical care experiences could not recall them without taking some time to reflect. Asking a single, direct question did not provide this time. However, by dividing the question into four parts, more time was provided for reflection, and the subquestions were able to guide the reflection more directly.

The question was structured, therefore, to minimize the loss of negative experiences. It may legitimately be asked whether in so structuring the question we instead elicited spurious negative experiences. The data indicate that we did not. In only two or three cases did we get a "yes" to this series of subquestions which, upon subsequent questioning, was found to be clearly unwarranted. (In these cases, the "yes" was changed to "no" and the respondent was coded as not having had a negative experience.) In all other cases, the respondent was able to give concrete details of a specific negative experience. This is not to say that all such experiences were of a serious nature; indeed, many were clearly minor. But the nature of the experiences, whether major or minor, was one of the questions which we wished to answer through this study.

Of the entire sample, 42.5% indicated that they, their spouses, or dependents, had had a negative medical care experience.[8] Those reporting incidents were asked how many incidents had occurred within the last 12 months, and how many within the last 10 years. These data are presented in Table 8. The average number of incidents reported for these two time periods are .252 and .868, respectively, based on the entire sample. If the rate of negative experiences had remained the same over the ten-year period, and if recall of experiences were not faulty, we would expect the ten-year average to be 10 times the one-year average. Instead, it is less than 4 times as large. This discrepancy could result from either a much higher rate of negative experiences during the last year, or faulty recall for previous years. In view of the known difficulty of having respondents accurately recall incidents several years in the past, and our experience with failure to recall during the questionnaire development and pretest stage of the study, it would be more realistic to attribute most, if not all, of the discrepancy to faulty recall. In other words, the rate for the ten-year period is probably somewhat higher than the .868 obtained.

The percentage of households reporting negative medical care experiences was quite high—over two-fifths of the population. Most recalled one or two incidents; only 10.5% claimed more than two incidents within the last 10 years.

Detailed questions were asked about the negative medical care experience. Persons with more than one experience were asked to describe the one experience which best fit this description, which was read to the respondent: "We are interested in those experiences where you felt a hospital or medical person made a mistake which caused harm; that is, suffering of any kind, injury to health, or extra expenses." The intention of this description was to elicit the experience which came closest to being an incident of malpractice as perceived by the respondent.

TABLE 8

DISTRIBUTION OF NUMBER OF NEGATIVE MEDICAL CARE EXPERIENCES FOR LAST 12 MONTHS AND LAST 10 YEARS

Number of Incidents	Percent (N = 1,011)
Last 12 months	
No incidents at all	57.8
None in last 12 months	25.5
One	12.0
Two	3.1
Three	0.8
Four or more	0.8
Total	100.0
Last 10 years	
No incidents at all	57.8
None in last 10 years	3.8
One	18.8
Two	9.0
Three	4.5
Four	2.4
Five	1.5
Six	1.1
Seven	0.2
Eight or more	0.8
Total	100.0

The next few paragraphs present the descriptive data given by the respondents in response to these questions about their negative medical care experiences. Percentages in this analysis will be based on the subpopulation of individuals reporting incidents (N = 432). It should also be noted that respondents were asked to choose for description an incident which had occurred within the last 10 years, *unless* their only incident(s) had occurred more than 10 years ago (as happened for only 3.8% of the population). This was to reduce memory distortion and to insure that incidents described were more relevant to current conditions.

Health care aspects of the negative medical care experiences.

This section will characterize the incidents from a medical point of view; that is, what the nature of the experience was, who was involved, what they did, etc. The following section will characterize the incidents in terms of the legal or other response made to the incident, if any.

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[8] It is important to emphasize that this figure does not refer to individuals, but rather to "household heads and their dependents" as the unit of analysis. This corresponds closely, but not exactly, with the household itself as the unit. The major discrepancies between these units are the following: dependents not living in the household are included (chiefly students away at school, or dependent elderly parents living elsewhere); nondependents living in the household (such as roomers) are excluded.

In the majority of incidents described (55.1%), the respondent was the patient, probably indicating that respondents recalled more, and recalled better, incidents happening to themselves, rather than to others. Incidents happening to spouses and to children were described with about equal frequency, 22.9% and 20.8%, respectively. The remaining 1.2% happened to dependent adults.

The majority of patients were described by respondents as being in good to excellent health prior to the incident. Table 9 presents this data together with the data describing the current health of the respondents for comparison purposes. Although the two populations are not the same, the comparison does indicate that patients with negative medical care experiences were not, in general, perceived to be in any worse health prior to the incident than were respondents at the time of the interview.

TABLE 9

STATE OF HEALTH FOR ALL RESPONDENTS (CURRENT HEALTH) AND FOR PATIENTS (HEALTH PRIOR TO INCIDENT)

	Percent	
State of Health	All Respondents, Current Health (N = 1,016)	Patients, Prior to Incident (N = 424)
Excellent	37.8	42.6
Good	42.4	39.0
Fair	14.3	13.5
Poor	5.5	5.0
Total	100.0	100.0

As can be seen in Table 10, the primary reason for seeking the medical care which later resulted in the negative experience, was in order to "diagnose or treat an illness or other condition." Among the remaining categories, to "treat an injury" is the most common. Only 8.1% were seeking a routine checkup. Thus, although most patients were perceived to be in good to excellent health during the year prior to the incident, most had some specific illness, injury, or other condition at the time they first sought the medical care which led to the incident.

Besides determining the original cause of seeking medical aid at the time the perceived incident occurred, it was also felt that it would be of great interest to determine the specific type of treatment being received at that time.

The three most common treatment types mentioned are oral medication (35.4%), surgery (17.4%), and needle injection of medication (15.3%). Two of these three (oral medication and needle injection) are very common modes of treatment for a wide variety of conditions; either as the core of the treatment program, or as a secondary aspect of the treatment. Ir is perhaps surprising that the percentages for these two modes were not even higher. The high percentage for surgery is important, however, as this is usually a much more serious and less frequently used mode of treatment. Thus, it may be that treatments involving surgery are much more likely to lead to dissatisfaction by the patient than most other forms of treatment.

TABLE 10

REASON FOR SEEKING MEDICAL CARE WHICH LED TO NEGATIVE EXPERIENCE

Reason	Percent (N = 420)
To diagnose or treat an illness or other condition	63.3
To treat an injury	15.7
For a routine checkup	8.1
To care for a pregnancy or deliver a baby	6.4
To receive psychiatric care	0.7
Something else	5.7
Total	100.0

TABLE 11

TYPE OF TREATMENT BEING ADMINISTERED WHEN NEGATIVE EXPERIENCE OCCURRED (MULTIPLE RESPONSES POSSIBLE)

Type of Treatment	Percent (N = 426)
Oral medication	35.4
Surgery	17.4
Needle injection	15.3
No treatment	13.9
Cast, tape, brace, stitches	7.4
Dental surgery	7.4
Miscellaneous	7.4
Radiation	6.4
Nonsurgical body entry	6.2
Physical therapy	6.0
Dental filling	4.8
Topical treatment	4.3
Bed rest	1.8
Mental or psychiatric therapy	0.4

To obtain a full description of the incident, it is important to establish whether and what kinds of negligence and/or damage the respondent felt was involved. However, it cannot be assumed that the respondent has a correct understanding of the meaning of the words "negligence" and "damage" when used with reference to malpractice. Also, the word "negligence" generally carries a perjorative connotation; using it in a question about the incident may result in answers distorted one way or the other, depending on the respondent's personl feelings towards the medical persons involved. Therefore, a series of open-end questions, followed by more specific, detailed questions were utilized rather than merely asking if they had been victims of negligence, or had suffered any damage. By this means, we attempted to determine, for example, whether the respondent felt that negligence was involved, even though the respondent may not have known what the term "negligence" implied.

The results for the series of questions dealing with negligence are presented in Table 12. Before discussing these results, the following point should be emphasized. These questions deal with respondents' perceptions, not matters of established fact. Furthermore, many of these items are only *possible* instances of negligence; that is, even if the respondents' perceptions were correct, this would not necessarily be an instance of malpractice. This is particularly the case for items 1 and 9 in Table 12; for the latter item, the question of "standard practice" is particularly important in establishing negligence, and that question is outside the capabilities of this research. Having emphasized this point, however, it is argued again that perceptions, whether correct or not, influence behavior and attitudes.

Respondents who had negative medical care experiences (N = 432) were asked the following open-end questions: "What, if anything, did any of the persons involved in your care *fail* to do or say which you feel should have been done or said as part of your care?" and "What, if anything, did any of the persons involved in your care do or say which you felt should *not* have been done or said as part of your care?" The responses to these two questions were coded together and are presented in the first column of Table 12. The open-end questions were followed later in the questionnaire by a series of specific yes/no questions, each asking the respondent if he felt the doctors involved in the incident had ever acted in a particular way. Each of these actions might constitute an instance of negligence, although the items were not presented to the respondent as such. Responses to these questions are presented in the second column of Table 12.

The types of possible negligence have been grouped into three broad categories in Table 12: errors of judgment, errors in dutifulness, and errors in skill. Errors in judgment are most frequently mentioned: more different errors of this type are mentioned in response to the open-end questions, and the two highest frequencies are found among these types for both open-end and fixed-answer questions. It should also be noted, however, that three of these items (4, 5 and 6) are among the least frequently mentioned. These all deal with length of stay in a hospital or institution. Errors in dutifulness are next most frequently mentioned, and errors in skill least frequently indicated, although even here the frequencies are not small.

From the open-end question it is possible to tell how many felt there had been no failure involved in the negative health care experience: 10.8% indicated there had been no failure, and 2.8% said they did not know.

One should not normally expect responses to these two different types of questions (open-end and fixed-answer) to be the same. The first measures features salient in the respondents's mind. Most respondents generate only one or two ideas in response to such questions. The second measures in a muct more direct fashion the perceived presence or absence of each of 10 actions constituting possible negligence, any one of which may or may not be salient to the respondent, and which may or may not have been construed by the respondent as a failure in the context of the open-end questions. Thus, the percentages are generally smaller for the open-end questions, as would be expected by the limited number of ideas generated by those questions for most respondents. However, the relative frequencies for most of those items common to both tables are quite similar. The discrepancy is quite large for three of the items, however (2, 8 and 10). One of these is an error of judgment (failed to take appropriate tests), and two are errors in dutifulness (failed to keep track of progress, and failed to disclose). Evidently, these items are not salient as failures, and are not likely to come to mind in response to the open-end question. Nevertheless, they are reported frequently when respondents are asked about them directly.

Several questions were also employed to determine perceived damages. First, respondents were asked whether the medical care caused the patient any unnecessary damage to appearance. They were also asked whether it caused any disability or impairment. If so, the respondent was asked whether he thought the damage to appearance or the disability was temporary or permanent. The results (Tabe 13) indicate that only a small proportion (18.3%) perceived any disability or impairment resulting from the medical care, and an even smaller proportion (12.8%) perceived damages to appearance. Nevertheless, of those who did perceive damage, the majority felt that it was permanent, for both types of damage.

Respondents were also asked if the medical care caused "any unnecessary pain, aggravation, inconvenience, or suffering." This question was intended to refer to damages normally classified as "pain and suffering." The incidence of this type of perceived damage is much higher—80.3% respond affirmatively to this question.

A third type of damage—economic—was investigated in another series of questions. These data (see Table 14) indicate that a majority (57.2%) felt that the medical care in question caused extra medical expenses. Smaller proportions felt that they had lost extra income or had extra nonmedical expenses. Respondents were then asked

TABLE 12

PROPORTIONS PERCEIVING VARIOUS TYPES OF POSSIBLE NEGLIGENCE INVOLVED IN THE NEGATIVE MEDICAL CARE EXPERIENCE, IN RESPONSE TO OPEN-END AND FIXED-ANSWER QUESTIONS (MULTIPLE RESPONSES POSSIBLE)

Type of Possible Negligence	Percent "Yes" to each type for: Open-end Q's (N = 424)	Fixed-answer Q's (N = 420)
Errors of Judgment		
1. Examined patient but failed to find out what was wrong	31.6	48.3
2. Failed to take appropriate tests	6.4	41.8
3. Prescribed the wrong treatment	19.5	25.8
4. Discharged from hospital before should have been discharged	1.7	8.7
5. Kept in hospital or institution longer than necessary	0.2	7.9
6. Required to stay in institution against patient's will	0.0	2.9
7. No treatment given	3.8	not asked
Errors in Dutifulness		
8. Failed to keep track of progress closely enough	6.1	40.9
9. Failed to warn of possible harmful side effects before beginning treatment or tests	13.7	23.4
10. Failed to tell what they thought was wrong with patient	0.0	22.7
11. Treatment too slow	1.8	not asked
Errors in Skill		
12. Incorrectly administered a test or treatment	19.1	38.1
13. Other form of mistreatment	11.5	not asked
Other Failures	3.1	not asked
No failure	10.8	not asked
Don't Know	2.8	not asked

TABLE 13

PERCENT SUFFERING DIFFERENT TYPES OF PHYSICAL DAMAGE RESULTING FROM MEDICAL CARE

Type of Damage	Percent				Total	N
	No	Yes				
		Temporary	Permanent	Don't Know		
Disability or impairment	81.7	0.5	12.5	5.3	100.0	422
Unnecessary damage to appearance	87.3	1.9	9.3	1.6	100.0	421

to estimate the total economic damages, not including expenses which were covered by insurance or other benefit programs.

TABLE 14

PERCENT SUFFERING DIFFERENT TYPES OF ECONOMIC DAMAGE RESULTING FROM MEDICAL CARE (MULTIPLE RESPONSES POSSIBLE)

Type of Economic Damage	Percent "Yes" to each item (N = 421)
Additional Medical Expenses	57.2
Additional lost income	37.3
Additional non-medical expenses	21.2

Responses to this question indicate that the amount of perceived economic damage was usually small or none among persons reporting negative medical care experiences. One-third, 33.3%, said they had no economic losses, 25.8% estimated their losses at less than $100. and 26.5%, at between $100. and $1,000. The percentages at the upper end of this scale are of more interest from the point of view of potential legal action. Damages of $5,000 to $10,000 were claimed by 1.9%; and damages of more than $10,000 by 1.9%, including two cases of $50,000 or more.

In summary, from the respondent's point of view, pain and suffering was the most frequent type of damage (claimed by four-fifths); economic damages were next most frequent (two-thirds), although the amount of damage was small for most; physical damage was least likely to be claimed—just over one-fifth perceived this type of damage.

Since many may be victims of medical malpractice and be unaware of it, whereas others may feel they are victims when, in fact, they have received adequate care, it is important to determine what factors lead to labelling medical care as unsatisfactory. Respondents were asked to identify factors leading to their dissatisfaction. Among these factors, by far the most important was having one's expections unmet (see Item 1, Table 15). It may be, of course, that the expectations of some patients are unreasonable, and they are bound to be disappointed. If so, some patient dissatisfaction might have been avoided had the doctors involved discerned the patient's expectations and, where necessary, attempted to redirect these expectations in more realistic directions. It is significant that respondents were infrequently led to dissatisfaction by the admission of error on the part of the doctor involved, but were frequently told of their unsatisfactory care by another medical person.

TABLE 15

PERCENTAGE INDICATING VARIOUS REASONS FOR BECOMING DISSATISFIED WITH MEDICAL CARE (MULTIPLE RESPONSES POSSIBLE)

Reason for Becoming Dissatisfied	Percent "Yes" to each item	N
1. Realized outcome of medical care was different from what was expected	78.0	414
2. Realized a new health problem had resulted	36.5	414
3. The medical person involved said he had made an error in treatment	6.3	417
4. Other medical person said care was unsatisfactory	40.8	418
5. Friend or relative said medical care was unsatisfactory	28.4	418

Health care responses to the negative medical care experiences

Of those with negative medical care experiences, 63.0% sought additional medical care after the experience. That is, in almost two-thirds of the cases the individuals involved felt that their health conditions after the incidents were such that additional care was required. Of those seeking additional care, the vast majority (82.6%) went to a medical person not involved in the original negative care. The remainder went back to someone involved in the original care, yet in over half of these cases (54% of the remainder) it was to a person whom they did not feel had contributed to the negative experience, even though they were involved in some way during the experience.

Only 50.2% of those who did not seek additional care failed to do so because they felt that additional care was unnecessary (in the sense that their health had already been restored). Other reasons given by respondents were: "nothing could be done" (that is, the damage could not be repaired), 24.5%; finanical reasons, 3.8%; too busy, or did not want to, 8.2%; other reasons, 15.3%. (Note: percents add to slightly more than 100% because a few respondents gave multiple responses).

In summary, the majority of persons who reported negative medical experiences did seek additional medical care, and usually from a person not involved in the original incident. Furthermore, only half of those who did not seek additional medical care did not do so because their health had already been restored to their satisfaction.

Legal responses to the negative medical care experiences.

In relation to legal remedies sought or considered, only 8% of those respondents who reported negative medical care experiences indicated that they had considered seeking legal advice, 92% indicating they had not considered such action. For those few who had considered legal action, the majority, 62%, indicated they or the patient (if not the respondent) had thought of the idea themselves; 23% indicated that the idea had originated with their spouse; and 15% with other relatives, friends, or doctors other than those involved in the negative experience. From the responses to this question, it would appear that the impetus for legal action is most often of individual and/or family origin, rather than being based on the initiation of trial lawyers or other doctors, as has frequently been maintained.

Consistent with this finding that motivation to consider legal action has little to do with factors outside the family, are the results of a question inquiring as to whether various media had influenced the respondent to consider legal action. In response to the question "Did any of the following play a part in your consideration of obtaining legal advice?" which was asked of those who indicated they had considered it, the following results were obtained for specific media.

Thus, though the media can be seen to play some role in leading people to consider legal action, it is a small role indeed.

TABLE 16

SAMPLE PERCENTS INDICATING INFLUENCE
BY VARIOUS TYPES OF MEDIA
TO CONSIDER LEGAL ACTION
(MULTIPLE RESPONSES POSSIBLE)

Type of Media	Percent "Yes" to each item (N = 34)
Newspaper	9
Magazine article	9
Book	9
Television program	18
Radio program	12

In attempting to discover respondents' motivations for considering legal action, the question "Why did you consider taking legal action?" was followed by several alternatives. The alternatives and the percent indicating each as a reason are given in Table 17.

TABLE 17

WHY DID YOU CONSIDER TAKING LEGAL ACTION?
(MULTIPLE RESPONSES POSSIBLE)

Reason	Percent "Yes" to each item (N = 34)
Pecuniary Reasons	
Obtain money to pay for all medical expenses	53
Obtain money to compensate for pain, aggravation, trouble, inconvenience, or suffering caused by the unsatisfactory medical care	53
Obtain money to pay for just those extra medical expsense which become necessary because of the unnecessary medical care	50
Obtain money to compensate for income lost when receiving this additional care or treatment	32
Obtain money to pay for all extra non-medical expenses caused by the unsatisfactory medical care	32
Obtain money to compensate for income lost because of disability	24
Non-pecuniary reasons	
Cause the person(s) involved to be held up to public notice	53
Cause the person(s) involved to lose their license(s) to practice	26

Although pecuniary reasons are of primary importance to respondents, it is evident from the results that the element of revenge is very important as well: 53% include "holding the persons involved up to public notice" among their reasons. Within pecuniary reasons, obtaining money to compensate for pain and suffering is just as important as obtaining money to compensate for actual expenses on lost income.

The number of respondents in the sample indicating they had considered legal action is 37, of which 14 actually talked to a lawyer or other legal advisor. Of the 23 who did not finally seek counsel, 12 indicated that they or the person involved had decided not to do so on their own initiative, while 6 indicated they had been dissuaded by a relative (5 by a spouse and 1 by some other relative living in the same household); 5 did not respond to the question.

Of those 14 people who actually took their case to a lawyer, 12 reported having their cases accepted by counsel.[9] One of the 2 people whose cases were rejected felt that the lawyer was justified in doing so, while the other did not feel that there was a justification in his case.

Of those 12 respondents whose cases were accepted by a lawyer, 6 eventually decided not to bring a claim, while 2 brought a claim but later withdrew it without settlement, 2 brought a claim but arrived at a settlement before trial, and 2 brought a claim which is still not settled. The frequencies involved here are too small to be used as the basis for any conclusions. Nevertheless they may be used as an indication of the direction in which the results of a larger study might go.

C. ASSOCIATIONAL RESULTS

Up to this point, the analysis has been almost exclusively descriptive, that is, while the distribution of the sample on a number of important variables has been presented, no attempt has been made to associate variables with each other. The remainder of the report therefore deals largely with these associations.

Due to time and space limitations, this part of the analysis will be mainly restricted to two primary dependent variables which reflect the major objectives of the study. Specifically, an attempt will be made to find variables which are associated with the number of perceived negative medical care experiences, and the legal response made after the one experience which the respondent described.

Number of Negative Medical Care Experiences

In the descriptive part of the analysis, the distribution of the number of incidents reported in the last ten years was presented and discussed (see Table 8). The objective here is to find variables which account to some of the variation in number of reported incidents.

As in most social research, demographic variables turn out to be strong predictors. The data for the significant variables are presented in Table 18. Bases shift slightly in the table due to individual item nonresponse. From the table it can be seen that the number of incidents reported is highly related to: marital status, income, religion, education, age, geographic mobility, and occupation ($p < .0005$ on the x^2 test of independence for each of these associations). Variables not significantly related to number of incidents are race and sex; therefore, they are not included in Table 18. With some exceptions in specific categories, the relationships of number of incidents to income, education, and geographic mobility are positive and the relationship to age is negative. There is also a generally positive, though not strictly monotonic relationship between number of incidents and occupational status.

There are a number of categories, as noted, which appear to be exceptions to these general associations. The youngest age group has a slightly lower, rather than higher, number of perceived incidents. Perhaps this is accounted for to some extent by a lower amount of exposure to health care services, since families headed by those in the youngest age group are likely to be the smallest (the highest rate of single-person families belongs to this age group) and to be composed of younger members. Another exception to the previously described relationship is that those with the most education (postgraduate) report fewer incidents than the college graduate group. It might be that those in the very highest educational category are able to secure better medical care (perhaps to some degree from people they know well) or perhaps they are more discerning in their perceptions of malpractice.

Three of these variables—education, income, and occupation—are very highly related to each other to begin with, and taken together are often considered as a composite measure for social status. In general, one would expect those of higher social status to be better able to obtain high quality medical care. Yet the findings on each variable consistently show that, in general, the higher the status, the more incidents reported. A partial explanation of this result may lie in the high social status of the medical profession. Doctors, in particular, rank high on the three status scales—education, income, and occupational status. Status differentials are maintained and acknowledged by various forms of deference. A form of deference which is particularly likely to be observed in the doctor-patient relationship is the patient's acceptance of the doctor's word and judgments as authoritative. It is tentatively suggested here that the greater the social distance between the doctor and the patient, the more likely this form of deference is to come into play, that is, those with lower status may be less likely to interpret negative outcomes as being the result of poor medical care.

It may be that the association of geographic mobility and age to the number of perceived incidents is largely explained by the association of these variables to the status variables just discussed, particularly education. That is,

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[9] In view of the fact that six of these cases were later withdrawn without a claim being filed, we cannot be sure that all of these cases were actually accepted by the lawyer. It is likely, however, that they were not *immediately rejected* by the attorney. That is, the lawyer may have decided that the case had enough merit to initiate a discovery procedure, but decided not to accept the case after some investigation.

TABLE 18

PERCENT DISTRIBUTIONS ON NUMBER OF INCIDENTS FOR EACH CATEGORY OF SELECTED DEMOGRAPHIC VARIABLES

Demographic Variable	Number of Incidents				N
	0	1	2+	Total Percent	
a. Marital Status					
Married	59.7	19.2	21.1	100.0	734
Separated, Divorced	47.2	29.2	23.6	100.0	89
Widowed	82.7	10.0	7.3	100.0	110
Never married	67.9	15.4	16.7	100.0	78
Total	61.7	18.8	19.5	100.0	1,011
b. Income					
Less than $2,000	68.3	19.5	12.2	100.0	41
$2,000 - $3,999	74.7	14.1	11.1	100.0	99
$4,000 - $5,999	71.0	16.1	12.9	100.0	124
$6,000 - $7,999	67.7	13.4	18.9	100.0	127
$8,000 - $9,999	56.3	22.2	21.5	100.0	135
$10,000 - $11,999	67.7	11.1	21.2	100.0	99
$12,000 - $14,999	50.7	27.6	21.6	100.0	134
$15,000 or more	51.7	22.4	25.9	100.0	205
Total	61.5	19.0	19.5	100.0	964
c. Religion					
Protestant	64.3	17.6	18.1	100.0	720
Catholic	60.8	19.1	20.1	100.0	194
Jewish	31.8	13.6	54.5	100.0	22
Other	45.5	27.3	27.3	100.0	11
None	48.4	32.3	19.4	100.0	62
Total	61.7	18.8	19.4	100.0	1,009
d. Education					
Grade school—0-8 yrs.	82.5	8.5	9.0	100.0	177
High school—9-11 yrs.	67.0	15.4	17.6	100.0	182
High school graduate—12 years	57.6	23.6	18.9	100.0	297
1-3 years of college	59.4	23.0	17.6	100.0	187
College graduate	39.3	19.1	41.6	100.0	89
Post graduate	49.4	21.5	29.1	100.0	79
Total	61.7	18.8	19.5	100.0	1,011

TABLE 18

(Continued)

Demographic Variable	Number of Incidents				N
	0	1	2+	Total Percent	
e. Age					
20 or less	56.3	15.6	28.1	100.0	32
21 - 30	46.1	15.2	28.7	100.0	258
31 - 40	52.0	20.9	27.1	100.0	177
41 - 50	61.8	19.7	18.5	100.0	173
51 - 60	70.1	16.5	13.4	100.0	164
61 - 70	81.5	11.3	7.3	100.0	124
71 or more	86.7	9.6	3.6	100.0	83
Total	61.7	18.8	19.5	100.0	1,011
f. Geographic mobility (number of moves between cities in last ten years)					
None	71.6	16.0	12.4	100.0	518
One	57.0	21.7	21.3	100.0	207
Two	45.7	22.3	31.9	100.0	94
Three, Four	50.4	19.1	30.4	100.0	115
Five or more	42.7	25.3	32.0	100.0	75
Total	61.6	18.8	19.5	100.0	1,009
g. Occupation					
Professionals	48.1	21.5	30.4	100.0	158
Managers & Proprietors	54.3	22.9	22.9	100.0	105
Sales & clerical	59.3	22.1	18.6	100.0	113
Craftsmen (skilled blue collar)	58.7	20.7	20.7	100.0	150
Operatives (semi-skilled blue collar)	57.4	16.3	26.4	100.0	129
Service	67.6	22.1	10.3	100.0	68
Laborers, except farm	76.8	14.3	8.9	100.0	56
Farmers & farm laborers	68.8	31.3	0.0	100.0	16
Armed forces	55.0	15.0	30.0	100.0	20
Unemployed, not in labor force, except retired	75.0	9.7	15.3	100.0	72
Retired	78.3	13.3	8.3	100.0	120
Total	61.7	18.8	19.6	100.0	1,007

older persons tend to have less education and geographically mobile persons tend to have more education. It may also be that those who move more often are to some extent more vulnerable to actual malpractice because of their ignorance about medical facilities in new locations. In addition, they may be less reserved about judging an incident as involving malpractice because they may be less well acquainted personally with the health care professionals involved.

Those who are widowed report the fewest number of incidents, followed by the never married, then the married, and finally the separated and divorced with the greatest number. Some of these differences may be accounted for by age (widows are oldest) and family size (widows and never marrieds come from the smallest families and hence have the least amount of family exposure to the medical profession). The category of divorced and separated does not fall into this pattern, however, and requires a separate explanation. It may be tentatively suggested, for example, that those who are more critical of others or who find it difficult to maintain interpersonal relationships may be both more likely to become separated and divorced, and more likely to be critical of a doctor's performance. It is not possible, of course, to test this explanation with the data available in the present study.

The religious differentials can largely be accounted for by the relationship of religion to the status variables, particularly education. The frequency of incidents for those of the Jewish faith is considerably higher than the frequency for any other religion. It should be noted that the Jews in the sample are disproportionately distributed at the high end of all three status variables—education, occupation, and income, which may, in turn, lead to the disproportionate number of incidents among Jewish persons.

Attitudes toward the medical profession constitute another major category of variables which one might expect to be related to the number of incidents reported. This association could arise in two different, though related, ways. People have a general tendency to maintain consistent attitude structures; that is, a given attitude tends to be consistent with other related attitudes held by the same person, and with related cognitions, or perceptions of experiences. Thus, persons experiencing what they perceive to be poor medical care may form attitudes toward medicine which are correspondingly negative, in order to maintain consistency. Second, and by the same token, attitudes can influence one's perceptions or interpretations of his experiences. Thus, those already holding negative attitudes will be more likely to interpret a given medical experience as negative than will a person who holds a more positive attitude when faced with the same situation. With the present data, it is not possible to sort out to what extent attitudes have influence perceptions, and to what extent the reverse has occurred. Certainly both processes may be assumed to be occurring, whereby attitudes and perceptions of experiences mutually influence and reinforce each other. Regardless of the direction of influence, however, the data do show a strong consistent relationship between attitudes and the number of negative medical care experiences. These data are presented and discussed below.

Two attitudes scales, which were introduced earlier in this paper attempted to measure the respondent's attitude towards the doctor-patient relationship and towards the technical competence of doctors. These scales, it will be recalled, where constructed by having respondents indicate, on a four-point scale, how well each of a number of positive statements about doctors applied to doctors in general. An overall measure for each scale was obtained by averaging the responses to the individual items, and redividing the resulting distribution via midpoint cutoffs into four categories of *very well*, *fairly well*, *not very well*, and *not at all.* Following from the preceding discussion, one would expect those reporting more negative medical care experiences to rate doctors at the low end of these two scales. This is clearly the case as seen in Table 19. Using the x^2 test of independence, the association is significant with $p < .0001$ for both attitudes.

Although both attitudes are strongly related to number of incidents, close examination of the tables reveals that the attitude towards doctor-patient relationship is even more strongly related than the attitude towards technical competence. In the description of the negative experiences presented earlier, it was noted that respondents are more likely to perceive negligence in their incidents than damage, particuarly if one restricts one's attention to physical damage—which is perhaps more closely related to technical competence of doctors than to negligence. That is, negative perceptions about the incidents seem to focus more strongly on aspects related to docter-patient relationships (negligence) than on aspects related to technical competence resulting in physical damage. To the extent that this is true, number of perceived incidents might be expected to be more strongly related to attitudes toward doctor-patient relationships than to attitudes toward doctor's technical competence.

Attitude consistency theory would also lead one to predict a positive association between number of incidents and belief that the doctor-patient relationship, as well as the technical competence of doctors, had deteriorated. Since respondents were asked to respond to these attitude items for doctors about 20 years ago, as well as today, it is possible to construct a variable comparing the ratings. The results of this analysis are presented in Table 20. This variable was constructed by subtracting the overall scale score of a respondent when rating doctors today, from his scale score when rating doctors 20 years ago. Since the individual scores range from 1.0 to 4.0, the differences range from -3.0 to +3.0. This distribution of differences was divided into six categories (-3.0 to -2.0, -2.0 to -1.0, etc.) which were labeled: *very much better*, *much better*, *somewhat better*, *somewhat worse*, *much worse*, *very much worse*. These six categories were further collapsed for Table 20 because of small N's in some categories.

Again, the x^2 test of independence shows that both attitudes are significantly related to number of incidents ($p < .0001$ for the first; $p < .05$ for the second). Examination of the table shows that the direction of thee relation is as predicted for the doctor-patient relationship variable—feeling that the relationship has deteriorated is associated with perceiving more negative experiences. For the technical competence variable, however, the direction is reversed for one category—those who feel doctors' technical competence is much better today perceive somewhat more, rather than fewer, incidents than do those who feel their competence is only somewhat better. A possible explanation for this irregularity is that those who feel that doctors' technical competence has become much, or very much better may now hold unrealistically high expectations about doctors' capabilities. When these expectations are not met in an actual experience, they may develop primarily negative feelings about the experience.

In two additional attitude items, respondents were asked whether they felt that doctors' dedication to their work had increased, decreased, or remained the same since a generation ago, and whether the amount of malpractice had increased, decreased, or remained the same over the last five years. These data again support the hypothesis of a consistency between attitudes and perceptions, as seen in

TABLE 19

ASSOCIATION BETWEEN NUMBER OF NEGATIVE INCIDENTS AND ATTITUDES TOWARDS DOCTOR-PATIENT RELATIONSHIP AND DOCTOR'S TECHNICAL COMPETENCE

a. Doctor-patient relationship scale

Number of Incidents	TOTAL	Attitude: On average, scale items describe doctors:			
		Very well	Fairly well	Not very well	Not at all
0	61.7	81.7	66.2	49.1	28.6
1	18.5	8.3	18.5	21.6	28.6
2+	19.8	10.1	15.3	29.3	42.9
Total	100.0	100.0	100.0	100.0	100.0
Number	971	109	524	324	14

b. Doctor's technical competence scale

Number of Incidents	TOTAL	Attitude: On average scale items describe doctors:		
		Very well	Fairly well	Not very well or Not at all
0	61.8	68.2	57.0	42.9
1	18.5	17.7	19.2	20.4
2+	19.6	14.0	23.8	36.7
Total	100.0	100.0	100.0	100.0
Number	988	485	454	49

Table 21. The x^2 test is significant with $p < .0001$ for both associations. It is interesting to note that those who respond "don't know" to the second variable (amount of malpractice) are least likely to report incidents, perhaps reflecting the influence of lack of education. Education was seen earlier to be positively related to number of incidents.

Respondents also demonstrate consistency when asked whether they feel the medical profession does a good job of regulating itself; of those responding "yes," 67.4% report no negative experiences, while the corresponding figure for those responding "no" is 39.5%. Those in the "don't know" category are again unlikely to report incidents—69.6% report no negative medical experiences.

The consistency is even stronger when the attitude is supported by corresponding behavior. Respondents were asked if they had ever disagreed with a doctor's diagnosis, and if so, whether they had ever gone to see a second doctor as a result. Of those never disagreeing with a doctor, 74.5% report no negative experiences; this percentage drops to 40.7% for those disagreeing but not going to a second doctor, and to 27.1% for those going to a second doctor as a result of the disagreement. These results are presented in Table 22.

A personality scale attempting to measure a person's intolerance of ambiguity was developed and included in the questionnaire. As we have seen, people generally tend to hold consistent attitudes. It might be predicted that this is even more the case for those who are more intolerant of ambiguity. It is suggested that those who are relatively more intolerant of ambiguity will attempt to resolve ambiguities through the easiest means possible—usually by changing attitudes or perceptions. Having received negative medical care is a potentially ambiguous situation for one who views doctors as being generally well trained, competent, and of high status. Resolving the ambiguity in this situation may be accomplished by either changing attitudes toward doctors (taking a more negative attitude), or changing perceptions of the medical care (deciding the care wasn't so bad after all). There is no strong *a priori* reason for suggesting which change—a change in attitudes or a change in perceptions—is more likely to occur. To the extent that a change in perception is more prevalent, we should expect those more tolerant of ambiguity to report fewer incidents. Conversely, to the extent that a change in attitudes is more prevalent, there should be no association between intolerance of ambiguity and number of incidents reported. The data (Table 23) show a tendency for those who are more intolerant of ambiguity to report fewer incidents. The association, however, is not very strong (the x^2 test does not quite reach significance at the $p = .05$ level).

TABLE 20

ASSOCIATION BETWEEN NUMBER OF NEGATIVE INCIDENTS AND ATTITUDE DIFFERENCES WHEN COMPARING DOCTORS ABOUT 20 YEARS AGO TO DOCTORS TODAY

a. Doctor-patient relationship scale

Number of Incidents	TOTAL	Attitude: On average scale items describe doctors:			
		Better (somewhat, much, and very much)	Somewhat worse	Much worse	Very much worse
0	62.3	72.9	64.4	54.7	25.9
1	18.3	12.9	19.3	19.2	22.2
2+	19.5	14.2	16.3	26.1	51.9
Total	100.0	100.0	100.0	100.0	100.0
Number	925	155	509	234	27

b. Doctor's technical competence scale

Number of Incidents	TOTAL	Attitude: On average, scale items describe doctors:			
		Better (much and very much)	Somewhat better	Somewhat worse	Worse (much and very much)
0	61.8	51.6	63.8	60.4	46.3
1	18.6	19.4	18.0	20.8	14.6
2+	19.6	29.0	18.3	18.7	39.0
Total	100.0	100.0	100.0	100.0	100.0
Number	952	31	640	240	41

Perhaps the overall conclusion to be drawn from the foregoing results is that there is evidently a marked tendence to make attitudes, perceptions, and possibly even behavior consistent when all relate to the subject of medical care. The direction of causality could be either way; the present cross-sectional data are unable to sort out whether attitudes are "causing" perceptions of incidents, or realistic perceptions of incidents are "causing" attitude formation. As pointed out earlier, it is perhaps most reasonable to assume that both are occurring in a continuous feedback process.

The frequency with which a person reports negative medical care experiences should also be related to the amount of exposure to the risk of a negative experience—operationalized as number of health care experiences. This variable was measured in two ways. First, "routine health care experience" was measured by adding together the average number of yearly visits the respondent has made to a doctor and to a dentist during the last few years. It should be noted that this variable pertains only to the respondent, whereas the variable "number of incidents" consists of the respondent's report of incidents including those to a spouse or dependent. This should weaken any association one might expect to obtain, since there is no measure of spouses' or dependents' experience included in the experience variable. Nevertheless, the data do show a relationship in the predicted direction (see Table 24) which is significant at the $p < .01$ level using the x^2 test. Examination of the table, however, reveals that almost all of the relationship is accounted for in the first two categories. That is, those with no visits per year report very few incidents, those with 1 to 2 visits, report a few more, and those with 3 or more visits report the most, but beyond 3 visits the number of incidents reported does not continue to increase.

Second, a variable was developed to measure "nonroutine health care experience." Respondents were asked a series of questions about the number of times they had been exposed in each of the following ways: nights in a hospital, and treatment in an emergency room (each of these referred to the respondent's lifetime); treatment through a hospital's outpatient services, and treatment by a doctor for illnesses and injuries (each of these referred to the last 10 years). A summary measure was developed by adding the responses to these 4 items together and grouping the results into 4 categories: almost no nonroutine experience; low; moderate; and high amount of experience. It is recognized that the accuracy of the responses to the

TABLE 21

ASSOCIATION BETWEEN NUMBER OF NEGATIVE INCIDENTS AND ATTITUDES TOWARD CHANGES IN DOCTORS' DEDICATION AND IN AMOUNT OF MALPRACTICE

Number of Incidents	Total	Over last generation, dedication has:		
		Increased	Remained the same	Decreased
0	61.5	70.5	65.6	51.4
1	18.8	15.0	17.9	22.0
2+	19.7	14.5	16.5	26.6
Total	100.0	100.0	100.0	100.0
Number	995	193	448	354

Number of Incidents	Total	Over the last five years, amount of malpractice has:			
		Increased	Remained the same	Decreased	Don't know
0	61.5	52.9	61.9	62.2	78.7
1	18.9	19.4	21.8	18.2	11.9
2+	19.6	27.7	16.2	19.6	9.4
Total	100.0	100.0	100.0	100.0	100.0
Number	1,006	346	357	143	160

TABLE 22

ASSOCIATION BETWEEN NUMBER OF NEGATIVE INCIDENTS AND DISAGREEMENT WITH A DOCTOR'S DIAGNOSIS

Number of Incidents	Total	Disagreement with diagnosis:		
		Has never disagreed	Disagreed, but hasn't seen second doctor	Disagreed and has seen second doctor
0	61.7	74.5	40.7	27.1
1	18.8	15.2	24.2	29.0
2+	19.5	10.3	35.1	43.9
Total	100.0	100.0	100.0	100.0
Number	1,009	711	207	91

TABLE 23

ASSOCIATION BETWEEN NUMBER OF NEGATIVE INCIDENTS AND INTOLERANCE OF AMBIGUITY

Number of Incidents	Total	Intolerance of ambiguity scale values: 1. (High intolerance)	2.	3. (Medium intolerance)	4.	5. (Low intolerance)
0	61.8	70.3	65.5	62.6	58.6	45.6
1	18.9	21.6	16.7	18.6	20.0	24.6
2+	19.4	8.1	17.9	18.8	21.4	29.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	997	37	252	431	220	57

individual items in this scale may not be high—memory losses and other factors will distort the answers, generally in a downward direction. However, the overall scale may be valid as an ordinal variable; that is, the categories represent relative, not absolute differences in amount of exposure. Table 24 shows the results for this variable which are also in the predicted direction and are highly significant ($p < .001$ for the x^2 test). That is, exposure as defined by the scale described above is positively related to the number of perceived incidents involving malpractice.

Negative perceptions of medical experiences might also be expected no be related to definitions of "malpractice." It might be expected that those whose definition is broad or vague might be more likely to report negative incidents than persons with a more restricted definition or persons who explicitly state that they are unaware of the definition. When these two variables are cross-tabulated, large differences in number of incidents do show up in these expected directions. These data are presented in Table 25. The association between these variables is significant with $p < .0001$ using the x^2 test of independence. Definitions were coded as completely correct if they linked damage and negligence by proximate cause. This definition is more restricted than those in any of the next three categories in the table, where the elements of negligence and damage are not linked. (For the third and fourth categories, for example, only negligence is implied in the definitions.) Likewise, those with an incorrect definition reported many incidents, whereas those who said they did not know the definition reported the fewest. Thus it would seem that those who are relatively sure of their knowledge, or of their lack of knowledge, tend to report fewer incidents than those who are less certain.

Legal Response[10] to the Negative Medical Care Experience

Results presented earlier indicated the respondents considered seeking legal advice infrequently in response to their perceived negative medical experience. Specifically, of those reporting negative experiences, only 37(8%) considered seeking legal advice and only 14 of these actually went so far as to see a lawyer. From the standpoint of the medical, legal, and insurance communities, however, these few individuals may be the ones who affect them most strongly and most directly. It is desirable, therefore, to determine what factors are associated with making what we shall term a legal response.

Two major hypotheses immediately suggest themselves. First, severity of perceived damage (whether physical, mental or economic) might be expected to be positively associated with making a legal response. That is, in general, the more that has been lost on any dimension as a result of the medical care, the stronger will be the motivation to recover as much of the loss as possible. A primary avenue of recovery, of course, is the legal system. However, given the motivation, recourse through the legal system will be sought only to the extent that it is known to be available and is believed to be relatively effective. This leads to the second hypothesis, namely, that amount of exposure to the legal system—particularly exposure which instills or reinforces a belief in its effectiveness-will be positively associated with making a legal

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[10] As used in this report, the term "legal response" refers to considering seeking legal advice, as well as to actually talking to a lawyer.

TABLE 24

ASSOCIATION BETWEEN NUMBER OF NEGATIVE INCIDENTS AND VARIOUS MEASURES OF AMOUNT OF HEALTH CARE EXPERIENCE

a. Routine health care experience

Number of Incidents	Total	Measure of Experience: 0 visits per year	1-2 visits	3-4 visits	5-6 visits	7 or more visits
0	61.8	80.6	63.0	56.5	59.1	57.6
1	18.8	11.2	19.2	21.0	19.4	18.5
2+	19.4	8.2	17.9	22.5	21.5	23.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	1,004	98	386	276	93	151

b. Nonroutine health care experience

Number of Incidents	Total	Measure of Experience: Almost none	Low	Moderate	High
0	61.7	75.8	66.6	58.9	45.0
1	18.8	12.8	19.6	18.7	23.1
2+	19.4	11.4	13.8	22.4	32.0
Total	100.0	100.0	100.0	100.0	100.0
Number	1,008	149	347	343	169

TABLE 25

ASSOCIATION BETWEEN NUMBER OF NEGATIVE INCIDENTS AND RESPONDENT'S DEFINITION OF "MEDICAL MALPRACTICE"

Definition	Number of Incidents: 0	1	2+	Total	N
Correct definition	66.0	18.0	16.0	100.0	50
Defined as damage, or damage and negligence	51.1	14.9	34.0	100.0	47
Defined as negligence only	55.3	22.1	22.6	100.0	385
Example given implying negligence only	54.4	23.0	22.6	100.0	226
Other example given	64.8	15.5	19.7	100.0	71
Incorrect definition	48.3	27.6	24.1	100.0	29
Don't know	84.1	9.0	7.0	100.0	201
Total	61.6	18.8	19.5	100.0	1,009

response to negative medical care experiences. We now turn to the data which, as shall be seen, give strong support to these hypotheses, particularly the first.

In presenting the data, it would be desirable to differentiate those who merely consider seeking legal advice from those who actually talk to a lawyer, as taking the latter step goes much beyond the former. However, the number of cases in these two categories are so few (23 and 14 respectively) that the cell frequencies in a cross classification table would ordinarily be too small to be reliable, particularly when there are more than two categories on the associated variable. In the analysis, therefore, these two categories will be collapsed.

The descriptions of the negative medical care experiences provide several variables related to the presence and severity of damages, whether economic, physical, or mental. Variables related to economic damage are presented in Tables 26-29, and those related to physical damage, in Tables 30-33. The bases in these tables shift somewhat due to item non-response. That is, those not responding to either question being associated in a particular table are not included. It should be kept in mind that the respondents included here are only those who reported negative medical care experiences. It should also be noted that many of the bases for individual category percents are quite small, and conclusions based on such percents should be viewed as tentative.

Respondents were asked to estimate within fairly broad categories, their total estimated economic losses as a result of the incident. As indicated earlier, most reported no losses or relatively small ones. However, the amount of loss is highly associated with considering seeking legal advice, as shown in Table 26. The sharpest increase occurs in the transition to losses of $100 or more. The proportion of respondents considering legal advice among those with estimated losses at $5000 or more is 25%, more than 6 times the figure for those with no economic losses. Even so, it is perhaps remarkable that with losses so high, still only one out of four even considered seeking legal advice.

Respondents were also asked what the nature of their economic losses were—extra medical expenses, extra non-medical expenses, or lost income. Of these three types, only the latter two are significantly associated with legal response. These data are presented in Tables 27 and 28. Coverage of most medical expenses by various insurance and benefit programs may keep the losses from this source within limits for most people. If so, this might account at least partially for the non-significance of the association of this variable with legal response. Although non-significant, it should be noted that the direction of the association is the same—if losses occurred, consideration of legal advice was more likely.

Respondents were also asked whether they felt the fee charged by the doctor was too high. This variable does not measure amount of damages in the same sense as the other three variables already considered, but it does indicate whether the respondent felt he was incurring losses because of excessive medical fees. , As can be seen in Table 29, this measure is also highly associated with legal response in the expected direction.

We turn next to the relation between legal response and damage to health. It is expected that those who sought additional medical care after the incident are more likely to feel that they had sustained some damage to their health, than are those who did not seek additional care. Therefore, they should be more likely to consider a legal response. When these two variables are cross-tabulated an association in this direction is found but it is not statistically significant. One further step may be taken, however. Among those not seeking additional medical care are some who felt that the damage to health was permanent, that health could not be restored. This group should be even more likely to consider a legal response than the group seeking additional care, since their injury is even

TABLE 26

LEGAL RESPONSE BY AMOUNT OF MONEY LOST
AS A RESULT OF THE NEGATIVE MEDICAL CARE EXPERIENCE
(Percents)

Considered Seeking Legal Advice	TOTAL	Amount of Money Lost				
		None	$99 or less	$100-$999	$1000-$4999	$5000 or more
Yes	8.6	3.8	4.7	12.1	18.6	25.0
No	91.4	96.2	95.3	87.9	81.4	75.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	405	133	106	107	43	16

$x^2 = 18.58$ with 4 df. $p < .01$.

TABLE 27

LEGAL RESPONSE BY WHETHER INCOME WAS LOST AS A RESULT OF THE NEGATIVE MEDICAL CARE EXPERIENCE
(Percents)

Considered Seeking Legal Advice	TOTAL	Whether Income was Lost	
		Yes	No
Yes	8.9	14.0	5.8
No	91.0	86.0	94.2
Total	100.0	100.0	100.0
Number	415	157	258

x^2 = 8.078 with 1 df. p = .005

TABLE 28

LEGAL RESPONSE BY WHETHER EXTRA NON-MEDICAL EXPENSES WERE INCURRED AS A RESULT OF THE NEGATIVE MEDICAL CARE EXPERIENCE
(Percents)

Considered Seeking Legal Advice	TOTAL	Whether Had Extra Non-Medical Expenses	
		Yes	No
Yes	8.7	15.7	6.8
No	91.2	84.3	93.2
Total	100.0	100.0	100.0
Number	414	89	325

x^2 = 7.066 with 1 df. p = .008

TABLE 29

LEGAL RESPONSE BY WHETHER FELT FEE WAS TOO HIGH AS A RESULT OF THE NEGATIVE MEDICAL CARE EXPERIENCE

(Percents)

Considered Seeking Legal Advice	TOTAL	Whether Felt Fee Too High	
		Yes	No
Yes	9.0	16.2	6.3
No	91.0	83.8	93.7
Total	100.0	100.0	100.0
Number	411	111	300

$x^2 = 8.49$ with 1 df. $p = .004$

greater. When this cross-tabulation is performed (See Table 30), this prediction is confirmed and the association is statistically significant.

One might also expect that the more ways in which health had been injured, the more likely would be a legal response. If this is true, those who felt they had sustained two or more kinds of damage should be more likely to consider seeking legal advice than those with only one kind of damage. The data (See Table 31) confirm this expectation. Only 2.5% of those perceiving no damage consider seeking legal advice, whereas 11.1% of those with one kind of damage and 29.2% of those with two or more kinds do so.

Physical injuries may result in disabilities. Thus having a disability, particularly one which has a severe effect on daily functioning, would be expected to be related to considering seeking legal advice. This is the case as can be seen in Table 32. There is a consistent monotonic rise in the proportion of those considering legal advice from 5.3% among those with no disability to 23.1% for those with a disability having a major to severe effect on daily functioning.

In a similar fashion, the severity of the physical injury, regardless of whatever disability it might produce, should be associated with considering seeking legal advice. The results, presented in Table 33, generally confirm this expectation. It should be noted, however, that those with a permanent, but minor injury, are less likely to consider seeking legal advice than those with a temporary, minor injury with delayed recovery, or those with a temporary but major injury (these two categories are treated together because there were only 10 cases in the second of these two categories). It may be that a minor permanent injury is viewed as being slightly less serious than a temporary but major injury, or a temporary injury with delayed recovery.

Respondents were asked whether the health care had resulted in any unnecessary damage to appearance, such as a large scar, a burn, or loss of hair. Following from the general hypothesis about damage, one would expect those responding affirmatively to this question to be more likely to consider seeking legal advice. This expectation is borne out by the data, as seen in Table 34. The association is statistically significant.

In summary, the general hypothesis that considering seeking legal advice is related to the perceived seriousness or severity of the negative experience is confirmed by the data.

It should be pointed out, however, that a few variables measuring damage and its severity were not found to be significantly associated with legal response. Variables measuring purely psychological injury (such as embarrassment, inconvenience, suffering other than pain, and loss of dignity) were not significantly associated with legal response. However, the deviations from the model of independence in each of these non-significant associations were in the predicted direction; that is, those perceiving more damage were slightly more likely to consider seeking legal advice.

Of the three categories of damage—economic, physical, and mental—it is easiest to associate a monetary value with the first, and most difficult to associate one with the last. This difficulty in evaluating psychological damage in monetary terms may account partially for the failure of the association between legal response and measures of psychological damage to reach statistical significance.

The second general hypothesis suggested earlier was that those with more exposure to law professionals and the legal system would be more likely to consider legal responses to their negative medical care experiences. It might be expected that this would be especially true if some of the previous exposure were directly related to medical malpractice. In addition it might be predicted that those whose exposure had reinforced a belief in the efficacy of the legal

TABLE 30

LEGAL RESPONSE BY WHETHER SOUGHT ADDITIONAL MEDICAL CARE AS A RESULT OF THE NEGATIVE MEDICAL CARE EXPERIENCE

(Percents)

Considered Seeking Legal Advice	TOTAL	Sought Additional Medical Care		
		Yes	No, nothing could be done	No, Other Reason
Yes	8.3	10.2	16.7	1.8
No	91.7	89.8	83.3	98.3
Total	100.0	100.0	100.0	100.0
Number	409	256	36	117

x^2 = 11.129 with 2 df. $p < .001$

TABLE 31

LEGAL RESPONSE BY KIND OF PHYSICAL DAMAGE RESULTING FROM THE NEGATIVE MEDICAL CARE EXPERIENCE

(Percents)

Considered Seeking Legal Advice	TOTAL	Kind of Physical Damage		
		None	One kind of damage: Injury, loss of function, pain, cosmetic damage, *or* other	Two or more kinds of damage
Yes	8.9	2.5	11.1	29.2
No	91.0	97.4	88.9	70.8
Total	100.0	100.0	100.0	100.0
Number	413	155	234	24

x^2 = 21.131 with 2 df. $p < .01$

TABLE 32

LEGAL RESPONSE BY SEVERITY OF DISABILITY RESULTING FROM THE NEGATIVE MEDICAL CARE EXPERIENCE (Percents)

Considering Seeking Legal Advice	TOTAL	Effect of Disability On Daily Functioning			
		No Disability	Disability with almost no effect	Minor to Moderate effect	Major to Severe effect
Yes	8.7	5.3	6.9	14.5	23.1
No	91.3	94.7	93.1	85.5	76.9
Total	100.0	100.0	100.0	100.0	100.0
Number	402	265	29	69	39

$x^2 = 17.063$ with 3 df. $p < .01$

TABLE 33

LEGAL RESPONSE BY SEVERITY OF PHYSICAL INJURY RESULTING FROM THE NEGATIVE MEDICAL CARE EXPERIENCE (Percents)

Considered Seeking Legal Advice	TOTAL	Severity of Physical Injury				
		No Physical Injury	Temporary		Permanent	
			Minor, no delay in recovery	Minor, delayed; or major	Minor	Major
Yes	8.9	2.1	4.5	14.4	10.0	34.4
No	91.0	97.9	95.5	85.6	90.0	65.6
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number	416	192	44	118	30	32

$x^2 = 42.132$ with 4 df. $p < .01$

TABLE 34

LEGAL RESPONSE BY WHETHER DAMAGE TO APPEARANCE RESULTED FROM THE NEGATIVE MEDICAL CARE EXPERIENCE

(Percents)

Considered Seeking Legal Advice	TOTAL	Any Necessary Damage To Appearance	
		Yes	No
Yes	8.9	16.7	7.8
No	91.0	83.3	92.3
Total	100.0	100.0	100.0
Number	415	54	361

x^2 = 4.59 with 1 df. p = .032

system in this situation should be most likely to make a legal response.

The most general measure of exposure to the legal system used here was a measure of the number of friends and relatives of the respondent who were lawyers. This variable emerged as virtually unrelated to tendency toward legal response, however, perhaps indicating that the measure of exposure was too indirect. Mere personal association with lawyers may not in itself lead to altered motivations or perceptions of need for legal counsel, or for that matter increased saliency of legal considerations in the context of a negative medical care experience.

A second variable measured more direct exposure to the legal system, per se. This was a measure based on whether the respondent, or someone known by the respondent, had ever sued or been sued, either on a matter relating to medical malpractice or on some other matter. The variable was coded in four categories: those with no exposure and those with low, moderate, and highest exposure. From Table 35 it can be seen that the association between this exposure variable and legal response is statistically significant, and the direction of the association is generally in the direction predicted. It should be noted, however, that the proportion of respondents considering seeking legal advice drops slightly in the category of highest exposure, rather than continuing to rise. Why this should be so is not clear, nor can the reason be discovered from the data available here.

The measure of exposure just discussed combined both exposure by suing and exposure by being sued. It seems reasonable to expect that of these two, exposure by suing would be most strongly related to legal response, since suing is the legal response most would ultimately be considering. In particular it is possible that those who sue once are most likely to do so again due to intra-individual factors of personality as well as knowledge of the legal system. The overall measure was therefore broken down into two sub-measures, one dealing with exposure by suing; the other, by being sued. The association of the latter with legal response emerged as statistically non-significant. The former, however, was associated with legal response at a higher level of significance than the overall measure (see Table 36). Again, however, there is a reversal in the direction of change, with those having the highest exposure responding less frequently than those with lower levels of exposure, although still at a higher level than those with no exposure at all. In this table, in fact, the reversal starts earlier and is even sharper than in the previous table.

In summary, the data provide evidence to support the second general hypothesis, that is, that exposure to the legal system is positively related to consideration of seeking legal advice. This association is stronger the more direct the exposure to the legal system.

In addition to the two general hypotheses which we have been discussing, it was thought that there might be variations in legal response caused by various other characteristics of the negative medical care experience. For example, those with certian types of illnesses, or undergoing certain types of treatments, or being treated by certain types of doctors might be more likely to consider seeking legal advice than others. The primary reasons for supposing that such variations exist are that different illnesses, procedures, etc., should vary in their risk of medical injury and should vary in the ability of patients to understand them, in terms of probable outcome, side effects, etc.

TABLE 35

LEGAL RESPONSE BY EXPOSURE TO SUING OR BEING SUED, FOR THOSE WITH NEGATIVE MEDICAL CARE EXPERIENCES
(Percents)

Considered Seeking Legal Advice	TOTAL	Amount of Legal Exposure			
		None	Low	Moderate	High
Yes	8.9	5.1	9.1	17.2	12.2
No	91.1	94.9	90.9	82.8	87.8
Total	100.0	100.0	100.0	100.0	100.0
Number	416	236	44	87	49

x^2 = 12.387 with 3 df. $p < .01$

TABLE 36

LEGAL RESPONSE BY EXPOSURE TO SUING, FOR THOSE WITH NEGATIVE MEDICAL CARE EXPERIENCES (Percents)

Considered Seeking Legal Advice	TOTAL	Amount of Exposure to Suing			
		None	Low	Moderate	High
Yes	8.9	5.2	19.4	17.5	8.6
No	91.1	94.8	80.6	82.5	91.4
Total	100.0	100.0	100.0	100.0	100.0
Number	416	270	31	80	35

x^2 = 16.09 with 3 df. $p < .01$

TABLE 37

LEGAL RESPONSE BY WHETHER RESPONDENT KNOWS ANYONE SEEING LAWYER ABOUT MAKING A MALPRACTICE CLAIM, FOR THOSE WITH A NEGATIVE MEDICAL CARE EXPERIENCE (Percent)

Considered Seeking Legal Advice	TOTAL	Whether Knows Anyone Seeking Lawyer about making a Malpractice Claim	
		Yes	No
Yes	8.3	16.7	7.5
No	91.7	83.3	92.5
Total	100.0	100.0	100.0
Number	411	36	375

x^2 = 3.664 with 1 df. p = .056

Therefore, a wide variety of variables characterizing the negative medical care experience along these kinds of dimensions were cross tabulated with the legal response variable. This analysis, however, proved largely unrewarding. Although weak associations did emerge, only one proved statistically significant, and even this could easily be due to chance in view of the large number of tables produced. This one significant result indicated that respondents having incidents involving surgeons were more likely to consider seeking legal advice than others. This one result, assuming that it is not merely due to chance, might be explained in part by the relatively higher risk of medical injury associated with surgical procedures. The higher malpractice insurance rates set for surgeons are most likely another reflection of this higher risk.

It was also thought that some of the variables measuring knowledge about malpractice would be related to legal response. For example, those aware of malpractice insurance might be more likely to consider legal action, while those who felt that suits take a long time and that few suits are won by the patient might be less likely to consider legal action. None of the variables proved to be associated with legal response, however.

One final measure derived from the description of the negative medical care experience was cross tabulated with the legal response variable. This was a measure of the extent to which the perceived experience, as described, met the criteria of a medical malpractice case. The variable placed respondents into four categories: those whose descriptions included the elements of negligence and damage, linked by proximate cause; those whose descriptions included damage, whether accompanied by negligence or not, but did not include proximate cause; those whose descriptions contained only the element of negligence; and those whose descriptions satisfied none of these criteria for malpractice. This variable, of course, only measures *perceived* malpractice. Even these perceptions may not be interpreted by the respondent as malpractice, since the respondent may be unaware of the correct definition. The measure was found to be significantly related to legal response, as can be seen in Table 38. As might be expected, those who perceive all the elements of medical malpractice are most likely to consider a legal response, whereas those who do not perceive all the elements are least likely to do so. Of the rest it seems that a perception of damage is more likely to lead to a consideration of legal response than is perception of negligence, perhaps because it is damages, not negligence, for which compensation would be sought.

The legal response variable was also cross tabulated with each of the demographic variables. Of these associations however, only one proved statistically significant (see Table 39). The association with race is highly significant, with blacks much more likely to consider a legal response than non-blacks. Furthermore, it appears that blacks may also be more likely to follow through and actually talk to a lawyer—5 of the 14 persons who actually talked to a lawyer were black. Because the sample size in one of the cells at this table is so small (N=10 in the black/yes cell) it is not possible to do a reliable control analysis with 3-way cross tabulation to try to account for this finding. However, since none of the other demographic variables was found to be related to the legal response variable, they cannot possibly account for the association, even though most are significantly associated with race. Since demographic variables frequently account for much of the association between race and other social variables, the failure of these variables in this instance raises interesting questions. Unfortunately a larger sample of blacks than is available here would be required to attempt a thorough analysis of this question.

TABLE 38

LEGAL RESPONSE BY PERCEIVED PRESENCE OF THE CRITERIA OF A MEDICAL MALPRACTICE CASE (Percents)

Considered Seeking Legal Advice	TOTAL	Perceived Presence of the Criteria for Medical Malpractice			
		None present	Negligence only	Damages (w/or w/o negligence)	Negligence as proximate cause of damages
Yes	8.5	0.0	3.2	6.3	16.1
No	91.6	100.0	96.8	93.7	83.9
Total	100.0	100.0	100.0	100.0	100.0
Number	404	29	156	64	155

$x^2 = 20.718$ with 3 df. $p < .01$

TABLE 39

LEGAL RESPONSE BY RACE (Percents)

Considered Seeking legal advice	TOTAL	Race	
		Black	White, Other
Yes	8.3	23.8	6.5
No	91.7	76.2	93.5
Total	100.0	100.0	100.0
Number	412	42	370

$x^2 = 14.950$ with 1 df. $p = .0002$

In summary, considering seeking legal advice is most strongly associated with a variety of variables which measure the amount of damage or injury the respondent felt was caused by the negative medical care experience. It is also associated with a smaller number of variables measuring amount of exposure to and experience with the legal system—those with more experience or exposure, particularly if it relates to bringing suit, are more likely to consider seeking legal advice. For the most part variables characterizing the nature of the medical experience—the type of illness, the treatment, the doctors involved, etc.—were not related to legal response. Also, none of the variables measuring knowledge about malpractice was found to be related to this variable. Finally, only one demographic variable, race, was significantly associated with considering seeking legal advice: blacks were much more likely to do so than whites.

Appendices

APPENDIX I

Report on Sampling and Completion Rates

A. SELECTION OF THE SAMPLE OF HOUSEHOLDS

Selection of the Primary Sampling Units

For the study, a general purpose national probability sample was employed which was designed to be representative of all housing units (HUs) in the conterminous United States, and which utilized area sampling methods.

In this sample, a primary sampling unit (PSU) is defined as a set of land areas which included 10,000 housing units at the time of the 1960 Census. In a given PSU, all the land areas were in the same Census division and community size group (See list below). In most cases, the land areas were located in one city, town, or county, or in an adjacent set of cities, towns, or counties. There was, however, great variation in the amount of land covered by a PSU. The smallest PSU selected in the sample covered about one square mile on the south side of Chicago, while the largest largest covered about 20,000 square miles of eastern Montana. The Census divisions and community size groups are listed below:

Census Geographic Division, 1960 Census	*States Included*
New England	Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island
Middle Atlantic	New York, Pennsylvania, New Jersey
East North Central	Ohio, Indiana, Illinois, Michigan, Wisconsin
West North Central	Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas
South Atlantic	Delaware, Maryland, District of Columbia, Virginia, North Carolina, South Carolina, Georgia, Florida
East South Central	Kentucky, Tennessee, Alabama, Missippi
West South Central	Arkansas, Louisiana, Oklahoma, Texas
Mountain	Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Neveda
Pacific	Washington, Oregon, California

Stratum	*Community Size Group*
A	Metropolitan areas over one million population—center city
B	Metropolitan areas over one million population—suburbs
C	Metropolitan areas under one million population—center city
D	Metropolitan areas under one million population-suburbs
E	Nonmetropolitan urban (towns of population 2,500 to 50,000)
F	Nonmetropolitan rural

The procedure followed in selecting the PSUs is described below:

Within each Census division, the states were listed beginning with the state in the northeast corner of the division, listing east to west, north to south in continuous serpentine order. Within the states, separately for community size strata A, B, C, and D, the metropolitan areas were rank-ordered by size, with the largest SMSAs first. Within each metro area, the housing units were listed in the order in which enumeration districts or city blocks are listed in Census publications.

For the nonmetropolitan areas, the counties within each state were listed in the same manner as were the states, starting in the northeast corner and listing in a serpentine fashion. With each nonmetropolitan county, the urban places with over 2,500 population which comprised stratum E were taken in the order listed by the Census. Similarly, the minor civil divisions comprising stratum F were taken in the order listed by the Census. In both cases, the housing units within the urban places and and other minor civil divisions were taken in the order they are listed in the Census list of enumeration districts.

Within each community size stratum, separately for each region, the numbers of housing units were cumulated and zones of equal size, namely 940,000 housing units were established. The boundaries of the zones cut cross cities, counties, tracts, blocks, and enumeration districts. Each zone was comprised of 94 equal sized primary sampling units of 10,000 housing units.

In some cases, zones did not include 940,000 actual housing units. This occurred because a zone did not cross from one Census division/community size stratum to another. Since none of the last zones of the strata included exactly 940,000 housing units, these zones were incomplete. Wherever this occurred, the zone was filled out with "paper housing units." These paper units were given the same probabilities of selection as real housing units. Thus there were several primary sampling units which consisted entirely of paper units, and a few, at the ends of the actual housing unit listings in the strata, which consisted of some actual housing units and some paper units.

Within each zone, two selections of primary sampling units were made, so that the probability of selection of a given PSU was (2 x 10,000)/940,000 = 1/47. Overall, 126 PSUs with actually existing HUs were selected. In most zones, two PSUs of 10,000 actual housing units each were selected, but there were many cases where 0 or 1 PSU of actual housing units was selected or where one of the selected PSUs consisted of fewer than 10,000 actual housing units in 1960. In most cases, the selected primary sampling units were sections of central cities, suburbs, towns, or rural areas that were contiguous and relatively homogeneous. However, there were cases where the PSU cut across county or SMSA boundaries and parts of the same PSU were separated by as many as 100 to 500 miles.

Because the desired sample size was small, we concentrated the interviewer workloads in order to minimize the expenses of hiring and training interviewers. We systematically subselected 40 of the 126 primary sampling units and restricted the study to these areas.

Selection of Listing Areas Within Sample PSUs.

Each of the 40 sample PSUs was subdivided into 125 Listing Areas each containing approximately 80 housing units or paper units in the case of incomplete zones based on 1960 Census data. These Listing Areas were blocks or combinations of blocks in most cases, but they all had clearly identifiable boundaries such as rivers, streets, and railroads or were combined into a set of Listing Areas which had clear boundaries. When an area surrounded by clear boundaries included well over 80 housing units in 1960, and could not be subdivided into smaller units with clear boundaries, two or more Listing Areas were combined into a larger cluster. This occurred primarily in large cities where apartment buildings were located.

In each PSU, 4 of the 125 Listing Areas were selected with equal probability of selection. Sketches of the boundaries of these Listing Areas were drawn in the office, household listing materials were assembled, the locations of the Listing Areas were indicated on maps, and all these materials were sent to the field for listing the households in the selected Listing Areas. The listings were then returned to the office where they were checked carefully in order to be as sure as possible that all housing units within the Listing Area boundaries had been included in the listings and that no housing units outside these boundaries had also been included. The listings were returned to the field for correction if mistakes were found or for verification if we did not have sufficient information to make a careful check.

Selection of Households Within Listing Areas.

When the listings were returned from the field, the households in each Listing Area were subdivided into segments of average size 5 households. It should be noted that many Listing Areas had undergone substantial changes in the number of households since 1960. While there were cases where most or all of the housing units in the Listing Area had been demolished or evacuated, a more common occurrence was that the Listing Area had grown to 2, 3 or more times what the size had been in 1960.

The number of segments thus reflected the number of listed households within the Listing Area. Segments were selected at the common interval of 1/9.71 in each Listing Area. Consequently, some Listing Areas having 9 or fewer segments had no segments selected for the sample, and others, which had undergone prodigious growth and now had well over 300 housing units, had 7 or 8 segments selected. These segments were contiguous housing units, single family dwellings lined up next to each other on a street, apartments on the same floor of an apartment building, or the separate housing units of a multi-unit structure. In all cases we attempted to make the boundary line between segments as clear as possible.

Within the selected households, the head and wife of head of household were selected with equal probability. Where the head of household was unmarried, the head was selected with certainty.

The overall probability of selection of a household is the product of: Pr(psu selected in original sample) x PR(psu subselected) x Pr(Listing Area selected within sample psu) x Pr(segment selected within sample Listing Area)=

$$1/47 \times 40/126 \times 4/125 \times 1/9.71 = 1/44924$$

The probability of selection of the household head or the wife of the household head in a household where there is both a head and a wife is ½ the probability of selection of the head of household in a household where there is no wife. Strictly speaking, this should be reflected in analyzing the data by weighting the interviews. Past experience indicates, however, that such weighting usually does not significantly alter the results which would be obtained by giving each interview equal weight.

B. EVALUATION OF THE SAMPLE AND THE COVERAGE OF THE POPULATION

Check the Coverage of Listed Households.

Our best estimate of the number of households in the continental United States in October, 1972 exclusive of military reservations is 65.728 million. This estimate is made by applying projected growth rate of households from April, 1970 to October, 1972 of 5%, as reported in *Current Population Reports,* Series P-25, No. 476, Table E, February, 1972, to the count of 63.448 million for April, 1970, as reported in the United States Census and adjusting for those located in Alaska and Hawaii or on military reservations in the continental United States.

Applying our sampling fraction of 1/44924, we expected to obtain

65.728 million/44924 =
1463 households in the sample.

There were, in fact, 1508 listings in the sample segments. Of these 58 were found not to be housing units, and 89 of these were vacant. The number of households thus included in the sample and found by the interviewers was 1361, as shown below:

Disposition of Household Listing	Number
Number of listings	1508
Number not housing units	58
Number vacant	89
Number of households	1361

The discrepancy between 1361 and 1463 is an estimate of the number of households not found by the interviewers. As such, we estimate the rate at which households were "found" by the interviewers to be

1361/1463 x 100% = 93.03%.

Comparing the numbers of households found by the interviewers in individual Listing Areas with the numbers listed in 1970 Census publications for individual blocks, we find that the majority of missed households were located in urban areas where there were many multi-unit structures. Listing in such areas, particularly where there are large numbers of transient hotels and rooming houses, is extremely difficult.

Coverage of the Population in Sample Households.

One thousand and seventeen interviews were obtained with eligible respondents in the sample households. Of the 1361 households we enumerated, we obtained household listings in 1190 of them, failing in the other 171 cases because of the refusal of the door answerer to divulge the information, or our inability to contact a member of the household who could give us the information. The nonresponse can be broken down into the following categories:

Type of Nonresponse	*Number*
Household Listings Not Obtained	171
No one home	58
Refused listing	97
Language barrier, door answerer	3
Housing unit not contacted	8
Interview not validated	5
Household Listing Obtained	173
Refused interview	119
Respondent absent for duration of study	20
Respondent not home when interviewer called	13
Language barrier, respondent	12
Respondent incapabile of interview senile, etc.	9
Total Response	344

However, those households with non-response of the types enclosed in parentheses are not normally considered part of the target population. Therefore, when these households are subtracted from the base we have, as the response rate within listed households:

1017/(1361-44)=1017/1317=77.22%

APPENDIX II

Group Moderator's Guide
Medical Care Experience

I. INTRODUCTION

A. Brief introduction to ISR and this study—mention gift
B. Brief comment on confidentiality of data
C. Explanation of video-taping

II. BACKGROUND VARIABLES

A. Name
B. Occupation
C. Number of children
D. Residence
E. Mobility—family doctor?

III. ABBREVIATED MEDICAL HISTORY

A. Relationship with medical community
    1. Existence of "family doctor"
    2. Social contact with members of medical profession
    3. Relatives who are members of medical profession
    4. History of medical care reveived before negative experience—type (MD, DDS, Osteopath, etc.) and frequency
B. Satisfaction with care received

IV. NEGATIVE MEDICAL CARE EXPERIENCE

A. Nature of problem
B. Factors leading to dissatisfaction with treatment
C. Sources of advice and information (family, friends, lawyer, other physician, etc.)
D. Efforts to seek restorative medical treatment
E. Efforts to seek legal redress
  1. If such efforts made—*why?* (Probe for feelings about physician and about adequacy of case)
  2. If not made—*why not?* (Probe for feelings about physician and about adequacy of case)
  3. Understanding of legal rights (before contact with attorney and now)
  4. Legal assistance which patient understands to be available before contact with attorney and now)

V. KNOWLEDGE OF THE MEDICAL MALPRACTICE PHENOMENON

A. What is meant by the term "medical malpractice?"
B. Whom would you contact if you felt that you had a major complaint against a physician?
C. Which group of doctors do you think is most often sued for malpractice? (e.g., DOs, specialists [which?])
D. Who else, besides physicians, do you think can be sued for malpractice?
E. Is medical malpractice increasing in this country?
  1. Why?
F. What effect do you think an increasing number of medical malpractice suits will have on the quality of medical care in this country?
G. Who do you think are most often the victims of medical malpractice? (poor, aged, etc.?)

VI. ATTITUDES TOWARD HEALTH CARE (AND OTHER) PROFESSIONALS

A. Identification of relative whenever physician
B. Identification of friend whenever physician
C. Quality of service offered by physicians (compared to other services)
  1. Changing for better or worse?
  2. Medicine an art or science—expectations, guarantee of work?
  3. If result of treatment is not as expected, what should be done about it?
  4. Cost of medical care
    a. Hospital costs rising—why?
    b. Do doctors charge too much?—personal experiences
E. Passing of "old Family Doctor"
  1. Attitudes toward specialization
F. Proper regulating agency—medical or public review boards
G. Proper role of legal and insurance communities

APPENDIX III

Questionnaire

(See Page 697)

BEGIN CARD 1

INSTITUTE FOR SURVEY RESEARCH
TEMPLE UNIVERSITY
–Of The Commonwealth System Of Higher Education–
PHILADELPHIA, PENNSYLVANIA 19121

FALL, 1972

STUDY 599-400-21
2-3

A STUDY OF

MEDICAL CARE EXPERIENCES

Time interview began: __________ A.M. __________ P.M.

Time interview ended: __________ A.M. __________ P.M.
22–24

RESPONDENT'S NAME: ______________________________

ADDRESS: ______________________________
(NUMBER) (STREET)

____
(CITY) (STATE) (ZIP)

AREA CODE & TELEPHONE NUMBER: ______________________________
(AREA CODE) (TELEPHONE NUMBER)

LA# ______________ 8–13

HU# ______________ 14–18

Good______________. I'm ______________
from the Institute for Survey Research of Temple University. We are conducting a national study of Medical Care Experiences and you have been selected to be part of that study.

INTERVIEWER'S NAME: ______________________________ ID# __________ DATE: __________
25–28 19–21

1. First, I'd like to ask a few questions about your health. In general, compared with the average person your age, would you describe your present health as:

	29
excellent,	1
good,	2
fair, or	3
poor?	4

2. Within the last few years, about how many days a year have you been unable to go about your normal activities or work because of illness or other health problems?

30–32

__________ DAYS A YEAR

3. About how many times a year do you usually see a dentist or dental specialist?

33–34

__________ TIMES A YEAR

4. About how many times a year do you usually see a physician?

35–36

__________ TIMES A YEAR

5. Do you have a family doctor?

		37
	Yes	1
(SKIP TO Q. 7)	No	2

6. About how long have you had this doctor?

38–40

_______ MONTHS OR _______ YEARS

7. Now I am going to read some statements. After each one, please tell me how well you think it describes doctors in general about 20 years ago. How about personally interested in patients? Do you think that describes doctors in general about 20 years ago very well, fairly well, not very well, or not at all? How about:

	VERY WELL	FAIRLY WELL	NOT VERY WELL	NOT AT ALL
a. Personally interested in patients	41 1	2	3	4
b. Competent and qualified	42 1	2	3	4
c. Willing to make house calls	43 1	2	3	4
d. Honest	44 1	2	3	4
e. Spends enough time with each patient	45 1	2	3	4
f. Effectively treats most illnesses and injuries	46 1	2	3	4
g. Explains things so patients understand	47 1	2	3	4
h. Usually discovers the cause of Symptoms	48 1	2	3	4

8. Now think about doctors today. After each statement, tell me how well you think it describes doctors in general today. How about personally interested in patients? Do you think that describes doctors in general today very well, fairly well, not very well, or not at all? How about:

	VERY WELL	FAIRLY WELL	NOT VERY WELL	NOT AT ALL
a. Personally interested in patients	49 1	2	3	4
b. Competent and qualified	50 1	2	3	4
c. Willing to make house calls	51 1	2	3	4
d. Honest	52 1	2	3	4
e. Spends enough time with each patient	53 1	2	3	4
f. Effectively treats most illnesses and injuries	54 1	2	3	4
g. Explains things so patients understand	55 1	2	3	4
h. Usually discovers the cause of symptoms	56 1	2	3	4

9. During your lifetime, how many nights have you had to stay in a hospital? Has it been:

	57
none	1
1 to 5,	2
6 to 10,	3
11 to 15, or	4
more than 15?	5

9a. During your lifetime, how many times have you been treated in the emergency room of a hospital? Has it been:

	58
none,	1
1 to 5,	2
6 to 10, or	3
more than 10?	4

10. During the last 10 years, how many times have you been treated through the outpatient services of a hospital? Has it been:

	59
none,	1
1 to 5,	2
6 to 10, or	3
more than 10?	4

11. During the last 10 years, how many different illnesses or injuries have you had which "received" a doctor's attention? Has it been:

	60
none,	1
1 to 5,	2
6 to 10, or	3
more than 10?	4

12. Not including close relatives, among the friends that you see socially, how many are:

	NUMBER
physicians? (SPECIFY TYPES): ______	61
dentists?	62
nurses?	63
other health care professionals? (SPECIFY TYPES): ______	64
lawyers?	65

13. What kind of insurance, if any, do you have which pays for your medical "and/or hospital" care expenses?

(CIRCLE CODE "1" FOR EACH ONE THAT APPLIES)	None	66 1
	Blue Cross	67 1
	Blue Shield	68 1
	Major Medical	69 1
	Medicare	70 1
	Other, group insurance (SPECIFY): ______	71 1
	Other, private insurance (SPECIFY): ______	72 1
	Other, government insurance (SPECIFY): ______	73 1

14. Compared with a generation ago, do you think that doctors today are more dedicated to their work, less dedicated, or that there is no difference?

		74
	More	1
	Less	2
(SKIP TO Q. 16)	No difference	3

15. Why do you say that?

16. How about people in general. Do you think they are more dedicated to their work today, less dedicated, or that there is no difference?

	75
More	1
Less	2
No difference	3

17. In general, what do you think medical malpractice is?

18. In the past five years, do you think that medical malpractice has been:

	76
increasing,	1
decreasing, or	2
has it remained the same?	3

19. Have you ever disagreed with a doctor's diagnosis, or with treatment recommended to you by a doctor?

		77
	Yes	1
(SKIP TO Q. 21)	No	2

20. Have you ever gone to a second doctor because you disagree with the first doctor's diagnosis or treatment?

	78
Yes	1
No	2

21. Do you think that the medical profession does a good job of regulating the practices of its own members?

	79
Yes	1
No	2

END CARD 1

BEGIN CARD 2

(HAND R CARD 1)

22. Now I'm going to read some statements about doctors. After each statement, tell me if you strongly agree, agree, disagree, or strongly disagree.

	STRONGLY AGREE	AGREE	DON'T KNOW	DISAGREE	STRONGLY DISAGREE
a. If a doctor doesn't fix up what's wrong with you, he shouldn't charge you for his services.	8 1	2	3	4	5
b. Doctors should be paid for results, not for their time.	9 1	2	3	4	5
c. Doctors should be put on monthly government salaries and should not charge patients for their services.	10 1	2	3	4	5
d. People make too much of medical science, for in the long run, it isn't able to help people much.	11 1	2	3	4	5
e. If a patient's health does not improve while under a doctor's care, his doctor should not charge him.	12 1	2	3	4	5
f. Doctors have to rely on hunches or guess work when treating patients.	13 1	2	3	4	5
g. Insurance companies are rich enough that it doesn't hurt anybody to cheat a little on health insurance.	14 1	2	3	4	5
h. The best way for a patient to get even with a doctor he doesn't like is not to pay doctor's bill.	15 1	2	3	4	5
i. If a doctor does something while treating a patient that costs the patient added pain, suffering, or time lost from his job, the doctor should be required to pay the patient damages.	16 1	2	3	4	5

23. If you had a serious complaint about medical care you had received from a doctor, whom, if anyone, would you contact? (PROBE): Anyone else?

(CIRCLE CODE "1" FOR EACH ONE THAT APPLIES)

No one	17 1
Same doctor	18 1
Other doctor	19 1
Medical Society	20 1
Local, State or federal official	21 1
Lawyer or Legal Aid	22 1
Insurance representative	23 1
Consumer group	24 1
Government agency	25 1
Hospital representative (SPECIFY): ______________________	26 1
Other (SPECIFY): ______________________	27 1
	28
	29

24. If you had a serious complaint about medical care you had received from a hospital, whom, if anyone, would you contact? (PROBE): Anyone else?

(CIRCLE CODE "1" FOR EACH ONE THAT APPLIES)

No one	30 1
Doctor	31 1
Medical Society	32 1
Local, state, or federal official	33 1
Lawyer or Legal Aid	34 1
Insurance representative	35 1
Consumer group	36 1
Government agency	37 1
Hospital representative (SPECIFY): ______________________	38 1
Other (SPECIFY): ______________________	39 1
	40
	41

25. Aside from doctors and nurses, would you approve of other specially-trained people providing medical care such as giving injections or treating minor injuries?

	42
Yes	1
No	2

(HAND R CARD 1)

26. Now I'm going to read some statements with which some people agree and others disagree. For each statement, tell me if you strongly agree, agree, disagree, or strongly disagree.

	STRONGLY AGREE	AGREE	D.K. UNCERTAIN	DISAGREE	STRONGLY DISAGREE
a. There is little chance for promotion on the job unless a person gets a break.	43 1	2	3	4	5
b. If you take good care of yourself you can avoid most medical problems.	44 5	4	3	2	1
c. There is little or nothing one can do towards preventing air pollution in our cities.	45 1	2	3	4	5
d. Whether or not you get a good doctor is just a matter of chance.	46 1	2	3	4	5
e. We are just so many cogs in life's machinery.	47 1	2	3	4	5
f. When you really get sick, there's not much you can do about it.	48 1	2	3	4	5
g. A doctor who doesn't come up with a definite answer probably doesn't know too much.	49 1	2	3	4	5
h. What we are familiar with is always better than what is unfamiliar.	50 1	2	3	4	5
i. A person who leads an even, regular life in which few surprises or unexpected happenings arise, really has a lot to be grateful for.	51 1	2	3	4	5
(CONTINUED ON NEXT PAGE)					

	STRONGLY AGREE	AGREE	D.K. UNCERTAIN	DISAGREE	STRONGLY DISAGREE
j. People who insist on a complete explanation from their doctor just don't know how complicated things really are.	52 5	4	3	2	1
k. A good job is one where what is to be done, and how it is to be done, are always clear.	53 1	2	3	4	5
l. It's more important for a doctor to know you well than to be an expert on the newest techniques.	54 1	2	3	4	5
m. Teachers or supervisors who make vague assignments give one a chance to show initiative and originality.	55 5	4	3	2	1
n. Many of our most important decisions are based on insufficient information.	56 5	4	3	2	1
o. There is really no such thing as a problem that can't be solved.	57 1	2	3	4	5

27. Do you have any close friends or relatives who have ever sued anyone?

		58
	Yes	1
(SKIP TO Q. 31)	No	2

28. Did any of the suits deal with poor medical care?

		59
	Yes	1
(SKIP TO Q. 30)	No	2

29. What was the outcome of the medical suit with which you are most familiar?

(CIRCLE ONE ONLY)

	60
Friend or relative won suit or settlement	1
Friend or relative lost suit or settlement	2
Suit dropped without settlement	3
No outcome as yet, pending	4
Don't know	5

(ALL SKIP TO Q. 31)

30. What was the outcome of the suit with which you are most familiar?

(CIRCLE ONE ONLY)

	61
Friend or relative won suit or settlement	1
Friend or relative lost suit or settlement	2
Suit dropped without settlement	3
No outcome as yet, pending	4
Don't know	5

31. Do you have any close friends or relatives who have ever been sued?

		62
	Yes	1
(SKIP TO Q. 35)	No	2

32. Did any of the suits deal with poor medical care?

		63
	Yes	1
(SKIP TO Q. 34)	No	2

33. What was the outcome of the medical suit with which you are most familiar?

(CIRCLE ONE ONLY)

	64
Friend or relative won suit or settlement	1
Friend or relative lost suit or settlement	2
Suit dropped without settlement	3
No outcome as yet, pending	4
Dont't know	5

(ALL SKIP TO Q. 35)

34. What was the outcome of the suit with which you are most familiar?

(CIRCLE ONE ONLY)

	65
Friend or relative won suit or settlement	1
Firend or relative lost suit or settlement	2
Suit dropped without settlement	3
No outcome as yet, pending	4
Don't know	5

35. Have you ever sued anyone?

		66
	Yes	1
(SKIP TO Q. 39)	No	2

36. Did any of the suits deal with poor medical care?

		67
	Yes	1
(SKIP TO Q. 38)	No	2

37. What was the outcome of the most recent medical suit?

(CIRCLE ONE ONLY)

	68
Respondent won suit or settlement	1
Respondent lost suit or settlement	2
Suit dropped without settlement	3
No outcome as yet, pending	4
Dont't know	5

(ALL SKIP TO Q. 39)

38. What was the outcome of the most recent suit?

(CIRCLE ONE ONLY)

	69
Respondent won suit or settlement	1
Respoddent lost suit or settlement	2
Suit dropped without settlement	3
No outcome as yet, pending	4
Don't know	5

39. Have you ever been sued?

		70
	Yes	1
(SKIP TO Q. 43)	No	2

40. Did any of the suits deal with poor medical care?

		71
	Yes	1
(SKIP TO Q. 42)	No	2

41. What was the outcome of the most recent medical suit?

(CIRCLE ONE ONLY)

	72
Respondent won suit or settlement	1
Respondent lost suit or settlement	2
Suit dropped without settlement	3
No outcome as yet, pending	4
Don't know	5

(ALL SKIP TO Q. 43)

42. What was the outcome of the most recent suit?

(CIRCLE ONE ONLY)

	73
Respondent won suit or settlement	1
Respondent lost suit or settlement	2
Suit dropped without settlement	3
No outcome as yet, pending	4
Don't know	5

43. Are you now:

	74
married,	1
separated,	2
divorced,	3
widowed, or	4
have you never married?	5

(INTERVIEWER: IF R HAS EVER MARRIED [CODES 1,2,3, & 4, Q. 43], include the "YOUR HUSBAND/WIFE" PHRASE WHEREVER INDICATED IN FOLLOWING QQ's)

44. Think now about medical care you, (your husband/wife) and your current dependents have received. Include visits to a doctor, dentist, chiropodist, therapist, or other medical person, as well as any experiences in a hospital or clinic. Have you:

	Yes	No
ever felt that mistakes were made in diagnosis, treatment or care?	75 1	2
ever felt that the medical care caused harm or injury in some way, or made the original problem worse?	76 1	2
ever felt that the medical care caused additional expenses, lost time or lost income which could have been avoided if the care had been given differently?	77 1	2
44a. Considering again medical care, you, (your husband/wife) and your dependents have received, have you ever been dissatisfied in any way with the quality of medical or dental care you, (your husband/wife) or your dependents have received?	78 1	2

(IF "NO" TO ALL FOUR, SKIP TO Q. 172)

45. Experiences such as these could be called negative medical care experiences. How many times has this happened to you, (your husband/wife) or your dependents within the last 12 months?

BEGIN CARD 3
8–9

______ NUMBER OF TIMES

46. How many times has this happened to you, (your husband/wife) or your dependents? "within the last 10 years"

10–11

______ NUMBER OF TIMES

(IF MORE THAN ONE EXPERIENCE [Q. 46], READ):

Think back over all these experiences. We are interested in those experiences where you felt a hospital or medical person made a mistake which caused harm; that is, suffering of any kind, injury to health, or extra expenses I would like to talk about the one experience which you feel best fits this description.

(ASK ALL):

12–13

47. In what year did this happen?

____
YEAR

48. To whom in your family did it happen?

14

	Self	1
(SKIP TO Q. 111)	Spouse	2
	Other male adult	3
	Other female adult	4
	Male child	5
	Female child	6

49. How old were you at the time?

____
AGE

15–16

50. What was the general state of your health in the year before this happened? Was it:

17

excellent,	1
good,	2
fair, or	3
poor?	4

51. Before this happened, had you been receiving medical care for any condition related to your negative medical care experience?

	18
Yes	1
No	2

52. Why were you seeking medical care when this negative medical care experience occurred? Was it:

		19
(ASK ONLY IF R IS FEMALE)	to care for a pregnancy or deliver a baby,	1
	for a routine checkup,	2
	to treat an injury	3
	to diagnose or treat an illness or other condition,	4
	to receive psychiatric care, or	5
	was it something else? (SPECIFY): ____________	6

53. What were your reasons for seeking medical care at that time? (PROBE FOR SYMPTOMS, TYPE OF ILLNESS OR INJURY)

54. Please describe exactly what your negative medical care experience was?

55. What kind of medication, therapy, surgery, or other treatment, if any, did you undergo as part of your care?

56. What, if anything, did any of the persons involved in your care fail to do or say which you feel should have been done or said as part of your care?

(IF NOTHING, SKIP TO Q. 58)

57. What persons were involved in this failure? (PROBE): Anyone else?

58. What, if anything, did any of the persons involved in your care do or say which you felt should not have been done or said as part of your care?

(IF NOTHING, SKIP TO Q. 60)

59. Who did this? (PROBE): Anyone else?

60. What kinds of physical, mental, or economic injuries or losses, if any, resulted from this negative medical care experience?

Now I would like to ask you some more specific questions about your negative experience. You may have answered some of thes questions already, but let me ask them anyway just to make sure I have all the important information.

61. Just before your negative experience occurred, did you feel that the need for medical care was urgent?

	20
Yes	1
No	2

62. At the same time, in terms of your health, what did you expect would be the result of the medical care you received?

63. Where did you first go for medical care?

(CIRCLE ONE ONLY)

	21
Hospital: emergency ward	1
Hospital: clinic	2
Hospital: general admission	3
Doctor's office	4
Received care at home	5
Other (SPECIFY): ______	6

64. What kind of medical professional did you go to first?

(CIRCLE ONE ONLY)

	22
Respondent's family doctor	1
Other general practitioner	2
Specialist (SPECIFY): ______	3
Dentist	4
Nurse	5
Other (SPECIFY): ______	6

65. Before treatment, if any, was begun, did any medical professional explain to you what they felt was wrong with you, or what they felt your condition was?

		23
	Yes	1
(SKIP TO Q. 70)	No	2

66. At that time, did you feel that the explanation was satisfactory?

		24
	Yes	1
	No	2

67. At the time the explanation was given, did you feel that it was correct?

		25
	Yes	1
	No	2

68. Do you still feel that way?

		26
(SKIP TO Q. 70)	Yes	1
	No	2

69. What made you change your mind?

70. Do you feel that any of the persons involved in your care or treatment in this case ever did any of the following?

	Yes	No	D.K.
failed to take appropriate tests?	27 1	2	3
required you to stay in a hospital, clinic, or institution against your will?	28 1	2	3
kept you in a hospital, clinic, or institution longer than you felt was necessary?	29 1	2	3
discharged you from the hospital before you should have been discharged?	30 1	2	3
failed to tell you what they thought was wrong with you?	31 1	2	3
examined you, but failed to find out what was wrong with you?	32 1	2	3
failed to keep track of your progress and condition closely enough?	33 1	2	3
failed to warn you of possible harmful side effects before beginning treatment or tests?	34 1	2	3
found out what was wrong with you, but prescribed the wrong treatment?	35 1	2	3
incorrectly administered a test or treatment?	36 1	2	3

71. Did your medical care involve any medication, therapy, surgery, or other treatment?

		37
	Yes	1
(SKIP TO Q. 77)	No	2

72. Where was this treatment mainly given? Was it:

	38
at home,	1
in a doctor's office, or	2
in a hospital or clinic?	3

73. How well were the expected results of the treatment explained to you before the treatment was begun? Were they explained:

	39
very well,	1
fairly well,	2
not very well, or	3
not at all?	4

74. Were any risks of the suggested treatment explained to you?

		40
	Yes	1
(SKIP TO Q. 76)	No	2

75. Who explained these risks?

76. Did the doctor specifically tell you that the treatment:

	41
definitely would be successful,	1
probably would be successful,	2
might not be successful, or	3
did he make no predictions?	4

77. Did the medical care cause any disability or impairment, either temporary or permanent?

		42
	Yes	1
(SKIP TO Q. 81)	No	2

78. What was this disability or impairment?

79. Do you still have this disability or impairment?

		43
	Yes	1
(SKIP TO Q. 81)	No	2

80. Do you think that this disability or impairment will be temporary, permanent, or don't you know?

	44
Temporary	1
Permanent	2
Don't know	3

81. Was there any unnecessary damage to your appearance, such as an unnecessarily large scar, a burn, discolored skin, or loss of hair?

		45
	Yes	1
(SKIP TO Q. 84)	No	2

82. What unnecessary damage to your appearance was there?

83. Was this damage temporary or permanent, or don't you know?

	46
Temporary	1
Permanent	2
Don't know	3

84. Think now about the time when you first became dissatisfied with the medical care which you received. Did any of the following lead to your dissatisfaction:

	Yes	No
You realized the outcome of the medical care was different from what had been expected.	47 1	2
You realized that a new health problem had resulted from the medical care received.	48 1	2
The medical person involved said that he had made an error in treatment.	49 1	2
Some other doctor or medical person said that the medical care was unsatisfactory.	50 1	2
A friend or relative said that the medical care was unsatisfactory.	51 1	2

85. As a result of this unsatisfactory medical care, did you have to spend money for extra medical expenses, including doctors, nurses, medicines, and so on?

	52
Yes	1
No	2

86. Did this unsatisfactory medical care cause you and your family to lose more income than would have been lost otherwise?

	53
Yes	1
No	2

87. Did the unsatisfactory medical care cause you any extra non-medical expenses, such as paying for a housekeeper or baby-sitter, or for transportation?

	54
Yes	1
No	2

(HAND R CARD 2)

88. Including lost income, all extra medical costs, and other related expenses, which were not paid back by insurance, employee or other benefit programs, about how much money did you and your family lose as a result of this negative medical care experience?

	55-56
No loss	01
$99 or less	02
$100 - $999	03
$1,000 - $1,999	04
$2,000 - $2,999	05
$3,000 - $3,999	06
$4,000 - $4,999	07
$5,000 - $9,999	08
$10,000 - $14,999	09
$15,000 - $19,999	10
$20,000 - $29,999	11
$30,000 - $49,999	12
$50,000 or more	13

89. Did the medical care cause you any unnecessary pain, aggravation, inconvenience, or suffering?

		57
	Yes	1
(SKIP TO Q. 91)	No	2

90. What kind of pain, aggravation, inconvenience, or suffering did it cause?

91. Did you feel at the time that the fee charged for the medical care was higher than it should have been?

	58
Yes	1
No	2

92. Did the doctor who was in charge at the time of the negative experience give you a satisfactory explanation of why the negative medical care experience occurred?

	59
Yes	1
No	2

93. Did any other medical person provide a better explanation?

	60
Yes	1
No	2

94. Following the negative medical care experience, what, if anything, did you do about it?

95. After the negative experience, did you seek any additional medical care?

		61
	Yes	1
(SKIP TO Q. 97)	No	2

96. From whom did you first seek this additional care?

			62
(CIRCLE ONE ONLY)	(SKIP TO Q. 98)	A person not involved in original care	1
		A person involved in original care but not contributing to the bad experience	2
		A person involved in original care and contributing to the bad experience	3

97. Why didn't you seek additional care?

(CIRCLE CODE "1" FOR EACH ONE THAT APPLIES)	Nothing could be done	63 1
	Additional care unnecessary	64 1
	Financial reasons	65 1
	Too busy	66 1
	Did not want to (SPECIFY)	67 1
	Other (SPECIFY): ____________	68 1
		69
		70

98. Did you ever consider seeking legal advice about the negative experience?

		71
(SKIP TO Q. 100)	Yes	1
	No	2

99. Why didn't you consider seeking legal advice?

(ALL SKIP TO Q. 172)

100. Who, if anyone, first suggested to you that you obtain legal advice?

(CIRCLE ONE ONLY)

	72
Spouse	1
Other relative in household	2
Other relative	3
Friend	4
Physician	5
Other person (SPECIFY): ______________________	6
No one (thought of it myself)	7

101. Did any of the following play a part in your consideration of obtaining legal advice:

	Yes	No
Newspaper article?	73 1	2
Magazine article?	74 1	2
Book?	75 1	2
Television program?	76 1	2
Radio program?	77 1	2

102. What legal rights did you feel you had in this case?

END CARD 3

BEGIN CARD 4

103. Why did you consider taking legal action? Did you hope to:

	Yes	No
obtain money to pay for all medical expenses?	8 1	2
obtain money to pay for just those extra medical expenses which became necessary because of the unsatisfactory medical care?	9 1	2
obtain money to compensate for income lost while you were receiving this additional care or treatment?	10 1	2
obtain money to compensate for income lost because of disability?	11 1	2
obtain money to pay for all extra non-medical expenses caused by the unsatisfactory medical care, such as having to hire extra household help?	12 1	2
obtain money to compensate for pain, aggravation, trouble, inconvenience, or suffering caused by the unsatisfactory medical care?	13 1	2
cause the person(s) involved to be held up to public notice?	14 1	2
cause the person(s) involved to lose their license(s) to practice?	15 1	2
Anything else? (SPECIFY): ______________________	16 1	2

104. Did you actually talk to a lawyer or other legal advisor about the case?

		17
(SKIP TO Q. 107)	Yes	1
	No	2

105. Who, if anyone, most influenced you not to talk to a lawyer?

(CIRCLE ONE ONLY)

	18
Spouse	1
Other relative in household	1
Other relative	1
Friend	1
Doctor involved in negative experience	1
Other doctor	1
No one (personal decision)	1
Other (SPECIFY): ____________	1

106. Why didn't you talk to a lawyer?

(ALL SKIP TO Q. 172)

107. Did the lawyer agree to take your case?

		19
(SKIP TO Q. 110)	Yes	1
	No	2

108. What reasons, if any, did the lawyer give for not taking your case?

109. Do you feel the lawyer was justified in not taking your case?

20

Yes	1
No	2

(ALL SKIP TO Q. 172)

110. What was the result of the case? Did you:

21

eventually decide not to bring a claim,	1
bring a claim but later withdraw it without a settlement,	2
bring a claim but arrive at a settlement before trial,	3
bring a claim to trial and lose,	4
bring a claim to trial and win, or	5
bring a claim which is still not settled?	6

(ALL SKIP TO Q. 172)

111. How old was (he/she) at that time?

22–23

_______ AGE

112. What was the general state of (his/her) health in the year before this happened? Was it:

24

	excellent,	1
	good,	2
	fair, or	3
	poor?	4
(DO NOT READ)	Don't know	5

113. Before this happened, had (he/she) been receiving medical care for any condition related to the negative medical care experience?

	25
Yes	1
No	2
Don't know	3

114. Why was (he/she) seeking medical care when this negative medical care experience occurred? Was it:

		26
(ASK ONLY IF PERSON WAS FEMALE OVER 12)	to care for a pregnancy or deliver a baby,	1
	for a routine checkup,	2
	to treat an injury,	3
	to diagnose or treat an illness or other condition,	4
	to receive psychiatric care, or	5
	was it something else? (SPECIFY): ____________	6
(DO NOT READ) (SKIP TO Q. 116)	Don't know	7

115. Tell me as best you can (his/her)reason for seeking medical care at that time? (PROBE FOR SYMPTOMS, TYPE OF ILLNESS OR INJURY)

116. Please describe exactly what (his/her) negative medical care experience was?

117. What kind of medication, therapy, surgery, or other treatment, if any, did (he/she) undergo as part of (his/her) care?

118. What, if anything, did any of the persons involved in (his/her) care fail to do or say which should have been done or said as part of (his/her) care?

(IF NOTHING OR DON'T KNOW, SKIP TO Q. 120)

119. What persons were involved in this failure? (PROBE): Anyone else?

120. What, if anything, did any of the persons involved in (his/her) care do or say which should not have been done or said as part of (his/her)care?

(IF NOTHING OR DON'T KNOW, SKIP TO Q. 122)

121. Who did this? (PROBE): Anyone else?

122. What kinds of physical, mental, or economic injuries or losses, if any, resulted from this negative medical care experience?

123. Now I would like to ask you some specific questions about this negative experience. You may have answered some of these questions already, but let me ask them anyway just to make sure I have all the important information. Where did (he/she) first go for the medical care which later resulted in this negative experience?

(CIRCLE ONE ONLY)

	27
Hospital: emergency ward	1
Hospital: clinic	2
Hospital: general admission	3
Doctor's office	4
Received care at home	5
Other (SPECIFY): ____________________	6
Don't know	7

124. What kind of medical professional did(he/she) go to first?

		28
(CIRCLE ONLY ONE)	Family doctor	1
	Other general practitioner	2
	Specialist (SPECIFY): ____________	3
	Dentist	4
	Nurse	5
	Other (SPECIFY): ____________	6
	Don't know	7

125. Before treatment, if any, was begun, did anyone explain to you or to (him/her) what they felt was wrong with (him/her), or what they thought (his/her) condition was?

		29
	Yes	1
(SKIP TO Q. 129)	No	2
	Don't know	3

126. At the time the explanation was given, did you feel that it was correct?

		30
	Yes	1
	No	2
(SKIP TO Q. 129)	Not applicable: not explained to R	3

127. Do you still feel that way?

		31
(SKIP TO Q. 129)	Yes	1
	No	2

128. What made you change your mind?

129. Do you feel that any of the persons involved in (his/her) care or treatment in this case ever did any of the following:

	Yes	No	D.K.
failed to take appropriate tests?	32 1	2	3
required (him/her) to stay in a hospital, clinic, or institution against (his/her) will?	33 1	2	3
kept (him/her) in a hospital, clinic, or institution longer than necessary?	34 1	2	3
discharged (him/her) from the hospital before (he/she) should have been discharged?	35 1	2	3
failed to tell what they thought was wrong with (him/her)?	36 1	2	3
examined (him/her), but failed to find out what was wrong with (him/her)?	37 1	2	3
failed to keep track of (his/her) progress and condition closely enough?	38 1	2	3
failed to warn (him/her) of possible harmful side effects before beginning treatment or tests?	39 1	2	3
found what was wrong with (him/her), but prescribed the wrong treatment?	40 1	2	3
incorrectly administered a test or treatment?	41 1	2	3

130. Did (his/her) medical care involve any medication, therapy, surgery, or other treatment?

		42
	Yes	1
(SKIP TO Q. 136)	No	2
	Don't know	3

131. Where was the treatment mainly given? Was it:

		43
	at home,	1
	in a doctor's office, or	2
	in a hospital or clinic?	3
(DO NOT READ)	Don't know	4

132. How well were the expected results of the treatment explained to you or to (him/her) before the treatment was begun? Were they explained:

		44
	very well,	1
	fairly well,	2
	not very well,	3
	not at all	4
(DO NOT READ)	Don't know	5

133. Were any risks of the suggested treatment explained to you or to (him/her)?

		45
	Yes	1
(SKIP TO Q. 135)	No	2
	Don't know	3

134. Who explained these risks?

135. Did the doctor specificially say that the treatment:

		46
	definitely would be successful,	1
	probably would be successful,	2
	might not be successful, or	3
	did he make no predictions?	4
(DO NOT READ)	Don't know	5

136. Did the medical care cause any disability or impairment, either temporary or permanent?

		47
	Yes	1
(SKIP TO Q. 140)	No	2
	Don't know	3

137. What was this disability or impairment?

138. Does (he/she) still have this disability or impairment?

		48
	Yes	1
(SKIP TO Q. 140)	No	2
	Don't know	3

139. Do you think that this disability or impairment will be temporary, permanent, or don't you know?

	49
Temporary	1
Permanent	2
Don't know	3

140. Was there any unnecessary damage to (his/her) appearance, such as an unnecessarily large scar, a burn, discolored skin, or loss of hair?

		50
	Yes	1
(SKIP TO Q. 143)	No	2
	Don't know	3

141. What unnecessary damage to appearance was there?

142. Was this damage temporary or permanent, or don't you know?

	51
Temporary	1
Permanent	2
Don't know	3

143. Think now about the time when you first became dissatisfied with the medical care which was received. Did any of the following lead to your dissatisfaction:

	Yes	No
(He/She) told you that (he/she) was dissatisfied.	52 1	2
You realized the outcome of the medical care was different from what had been expected.	53 1	2
You realized that a new health problem had resulted from the medical care received.	54 1	2
The medical person involved said that he had made an error in treatment.	55 1	2
Some other doctor or medical person said that the medical care was unsatisfactory.	56 1	2
A friend or relative said that the medical care was unsatisfactory.	57 1	2

144. As a result of this unsatisfactory medical care, did you or your family have to spend money for extra medical expenses, including doctors, nurses, medicines, and so on?

	58
Yes	1
No	2

145. Did this unsatisfactory medical care cause you and your family to lose more income than would have been lost otherwise?

	59
Yes	1
No	2

146. Did the unsatisfactory medical care cause you or your family any extra non-medical expenses, such as paying for a housekeeper or baby-sitter, or for transportation?

	60
Yes	1
No	2

(HAND R CARD 2)

147. Including lost income, all extra medical costs and other related expenses, which were not paid back by insurance, employee or other benefit programs, about how much money did you and your family lose as a result of this negative medical care experience?

	61-62
No loss	01
$99 or less	02
$100 - $999	03
$1,000 - $1,999	04
$2,000 - $2,999	05
$3,000 - $3,999	06
$4,000 - $4,999	07
$5,000 - $9,999	08
$10,000-$14,999	09
$15,000-$19,999	10
$20,000 - $29,999	11
$30,000-$49,000	12
$50,000 or more	13

148. Did the medical care cause (him/her) any unnecessary pain, aggravation, inconvenience, or suffering?

		63
	Yes	1
(SKIP TO Q. 150)	No	2
	Don't know	3

149. What kind of pain, aggravation, inconvenience, or suffering did it cause (him/her)?

150. Did the medical care cause you any unnecessary pain, aggravation, inconvenience, or suffering?

		64
	Yes	1
(SKIP TO Q. 152)	No	2

151. What kind of pain, aggravation, inconvenience or suffering did it cause you?

152. Did you feel at the time that the fee charged for the medical care was higher than it should have been?

	65
Yes	1
No	2

153. Did the doctor who was in charge at the time of the negative experience give you a satisfactory explanation of why the negative medical care experience occurred?

	66
Yes	1
No	2

154. Did any other medical person provide a better explanation?

	67
Yes	1
No	2

155. Following this negative medical care experience, what, if anything, did you or did (he/she) do about it?

156. After the negative experience, was any additional medical care sought?

		68
	Yes	1
(SKIP TO Q. 158)	No	2

157. From whom was this additional care first sought?

			69
(CIRCLE ONE ONLY)	(SKIP TO Q. 159)	A person not involved in original care	1
		A person involved in original care but not contributing to the bad experience	2
		A person involved in original care and contributing to the bad experience	3

158. Why wasn't additional care sought?

(CIRCLE CODE "1" FOR EACH ONE THAT APPLIES)

Nothing could be done	70 1
Additional care unnecessary	71 1
Financial reasons	72 1
Too busy	73 1
Did not want to (specify)	74 1
Other (SPECIFY): ________________	75 1
	76
	77

159. Did you or did (he/she) ever consider seeking legal advice about the negative experience?

		78
(SKIP TO Q. 161)	Yes	1
	No	2
(SKIP TO Q. 172)	Don't know	3

160. Why didn't you consider seeking legal advice?

(ALL SKIP TO Q. 172)

BEGIN CARD 5

161. Who, if anyone, first suggested that you or (he/she) obtain legal advice?

(CIRCLE ONE ONLY)

	8
Spouse	1
Other relative in household	2
Other relative	3
Friend	4
Doctor	5
Other person (SPECIFY): ____________	6
No one (Thought of it myself)	7
(He/She) thought of it (him-/her-)self	8
Don't know	9

162. Did any of the following play a part in your or (his/her)consideration of obtaining legal advice:

	Yes	No	D.K.
Newspaper article?	9 1	2	3
Magazine article?	10 1	2	3
Book?	11 1	2	3
Television program?	12 1	2	3
Radio program?	13 1	2	3

163. What legal rights did you feel you or (he/she) had in this case?

164. Why did you or (he/she) consider taking legal action? Did you or (he/she) hope to:

		Yes	No
obtain money to pay for all medical expenses?	14	1	2
obtain money to pay for just those extra medical expenses which became necessary because of the unsatisfactory medical care?	15	1	2
obtain money to compensate for income lost while (he/she) was receiving this additional care or treatment?	16	1	2
obtain money to compensate for income lost because of disability?	17	1	2
obtain money to pay for all extra non-medical expenses caused by the unsatisfactory medical care, such as having to hire extra household help?	18	1	2
obtain money to compensate for pain, aggravation, trouble, inconvenience, or suffering caused by the unsatisfactory medical care?	19	1	2
cause the person(s) involved to be held up to public notice?	20	1	2
cause the person(s) involved to lose their license(s) to practice?	21	1	2
Anything else? (SPECIFY): ______________________	22	1	2

165. Did you or (he/she) actually talk to a lawyer or other legal advisor about the case?

		23
(SKIP TO Q. 168)	Yes	1
	No	2

166. Who, if anyone, most influenced you or (him/her) not to talk to a lawyer?

(CIRCLE ONE ONLY)

	24–25
Spouse	01
Other relative in household	02
Other relative	03
Friend	04
Doctor involved in negative experience	05
Other doctor	06
No one (R's own decision)	07
No one (he/she decided him-/her-) self	08
Other (SPECIFY): ____________	09
Don't know	10

167. Why didn't you or (he/she) talk to a lawyer?

(ALL SKIP TO Q. 172)

168. Did the lawyer agree to take the case?

		26
(SKIP TO Q. 171)	Yes	1
	No	2

169. What reasons, if any, did the lawyer give for not taking the case?

170. Do you feel the lawyer was justified in not taking the case?

	27
Yes	1
No	2

(ALL SKIP TO Q. 172)

171. What was the result of the case? Did you or (he/she)

	28
eventually decide not to bring a claim,	1
bring a claim but later withdraw it without a settlement	2
bring a claim but arrive at a settlement before trial,	3
bring a claim to trial and lose,	4
bring a claim to trial and win, or	5
bring a claim which is still not settled?	6

172. How many people do you know personally who have seen a lawyer about making a medical malpractice claim?

29

____

NUMBER OF PEOPLE

(IF 0, SKIP TO Q. 174)

173. How many people do you know personally who have won money after making a medical malpractice claim?

30

____
NUMBER OF PEOPLE

174. In the past year, what percentage of U.S. physicians do you think were sued for medical malpractice? Just give us your best guess.

31–32

____
PERCENTAGE

175. In the past five years, do you think this percentage has:

33

increased,	1
remained the same, or	2
decreased?	3

176. What effects, if any, do you think an increasing number of malpractice suits would have on medical care you and your family may need?

177. In general, what do you think is likely to happen to a physician who loses a malpractice suit?

(CIRCLE CODE "1" FOR EACH ONE THAT APPLIES)

Nothing	34	1
Lose license	35	1
Damage reputation	36	1
Increased insurance rates	37	1
Lose malpractice insurance	38	1
Lose money	39	1
Other (SPECIFY) ________________	40	1
	41	
	42	

178. If you went to a lawyer about a malpractice suit, do you think he:

43

would charge a fixed amount,	1
would charge a percentage of any money awarded,	2
would charge a fixed amount plus a percentage of any money awarded, or	3
would charge by the hour?	4

179. Do you think that most lawyers would require that you pay some money before they would take your case?

44

Yes	1
No	2
Don't know	3

180. Of those who bring a medical malpractice suit against a doctor or hospital, about what percentage do you think get money? Just give me your best guess.

____
PERCENTAGE

45–46

181. About how long do you think it takes to get money from a malpractice suit?

______ MONTHS OR ______ YEARS 47–49

182. Can doctors buy insurance which would cover their expenses resulting from a malpractice suit?

		50
	Yes	1
(SKIP TO Q. 186)	No	2
	Don't know	3

183. About what percentage of the doctors in the United States do you think have such malpractice insurance? Just give me your best guess.

______ PERCENTAGE 51-52

184. About how much a year do you think it costs most doctors to buy malpractice insurance?

______ DOLLARS A YEAR 53–57

185. About how many dollars of insurance coverage do you think this would buy?

______ DOLLARS 58–61

186. Do you remember ever reading about a malpractice suit in a newspaper or magazine or ever hearing about one on radio or television?

	62
Yes	1
No	2

187. How many members of your family or close relatives are:

	NUMBER
physicians? (SPECIFY TYPES): ________	63
dentists, or dental specialists?	64
lawyers?	65
nurses?	66
other health care professionals? (SPECIFY TYPES): ________	67

188. Who is the person who provides the most financial support for this household?

	68
Self	1
Spouse	2
Respondent's parent (-in-law)	3
Respondent's child	4
Other (SPECIFY): ________	5

(ASK QQ. 189 AND 190 ABOUT PERSON NAMED IN Q. 188)

189. What is (your/his/her) occupation? What kind of work do(es) (you/he/she) do?

OCCUPATIONAL TITLE

OCCUPATIONAL DUTIES

190. What kind of business or industry is that?

BUSINESS OR INDUSTRY

191. Here is a card showing amounts of weekly and yearly incomes. (HAND R CARD 3) Next to each amount is a letter. Would you tell me what letter represents the income your family expects to receive before taxes in 1972--include all sources such as wages, profits, tips, interest, and so on?

LETTER 69–70

192. What is your religion, if any?

		71
	Protestant	1
(SKIP TO Q. 194)	Roman Catholic	2
	Jewish	3
	None	4
	Other (SPECIFY):	5

193. What denomination? 72–73

____

DENOMINATION

194. How important would you say religion is to you? Is it:

	74
very important,	1
fairly important,	2
fairly unimportant, or	3
not at all important?	4

195. What is the last grade of school which you completed?

(CIRCLE ONE NUMBER)

	75–76
No schooling	0
Elementary	1 2 3 4 5 6 7 8
High School	9 10 11 12
College	1 2 3 4 5+

(ASK Q. 196 ONLY IF R IS MARRIED AND LIVING WITH SPOUSE[Q. 43]. ALL OTHERS SKIP TO Q. 197)

196. What is the last grade of school which your (husband/wife) completed?

(CIRCLE ONE NUMBER)

	77–78
No schooling	0
Elementary	1 2 3 4 5 6 7 8
High School	9 10 11 12
College	1 2 3 4 5+

END CARD 5

BEGIN CARD 6

8–9

197. What is your date of birth?

_______ MONTH _______ DAY _______ YEAR

198. How many different times have you moved in the last 10 years? Do not count moves within the same city.

10–11

_______ NUMBER

199. How many children "under 18" are dependent on you (and your husband/wife) for over half of their support? Include dependent children not living in your household.

12–13

_______ NUMBER

200. Not including your (self/selves), how many adults "18 or over" are dependent on you (and your husband/wife) for over half their support? Include dependent adults not living in your household.

14–15

_______ NUMBER

THANK YOU

(INTERVIEWER: RECORD FROM OBSERVATION)

201. Race of respondent:

	16
Black	1
Oriental	2
White	3
Other (SPECIFY): ____________	4

(INTERVIEWER: RECORD ANSWERS TO FOLLOWING QUESTIONS)

202. Respondent's cooperation was:

	17
Very good	1
Good	2
Fair	3
Poor	4

203. Did the respondent have any trouble understanding any questions?

		18
	Yes	1
(SKIP TO Q. 205)	No	2

204. (IF "YES"): WHICH ONES? (INTERVIEWER, RECORD NUMBERS) 19–30

____

205. Other persons present during interview were:

(CIRCLE CODE "1" FOR EACH ONE THAT APPLIES)

No one	31 1
Children under 6	32 1
Children over 6	33 1
Spouse	34 1
Parent (-in-law)	35 1
Other relative(s)	36 1
Other adult(s)	37 1

PATIENT GRIEVANCE MECHANISMS IN HEALTH CARE INSTITUTIONS

Fargo Thompson
Andrew Lupton
Richard Renck, Ph.D.
James Feldesman

Summary

This study had two primary objectives:

1) to *inventory* the patient grievance mechanisms that currently exist, including their operating patterns and characteristics.
2) to *develop model patient grievance mechanisms* that would provide the patient with adequate channels for his complaints while helping health care institution administrators improve the quality of care.

In conducting this study six identifiable but closely linked steps were undertaken. These were:

1) to review the recent literature on patient grievance mechanisms and other forms of complaint processes through which consumers voice their dissatisfactions;
2) to discuss the aspects of patient grievance mechanism with four individuals generally recognized as having a broadgauged knowledge of the field. These discussions enabled us to identify approximately 40 institutions that were perceived as having exemplary systems;
3) to develop interview guides for on-site interviews separated as to type of respondent (e.g., administrator, physician, insurance representative); to schedule 16 primary and eight secondary (head of mechanism and institution's top administrator only) interviews; conduct these interviews;
4) based on these interviews,
    a) prepare case studies depicting the operation, staffing, authority and scope of the systems visited;
    b) develop a mail questionnaire that was sent to over 2,000 health care institutions drawn from the American Hospital Association's list of institutions with over 200 beds and federally supported institutions (VA hospitals, OEO Neighborhood Health Centers, etc.);
5) develop 3 basic model systems and a "key factor sheet" that was designed to allow each respondent to *pick and rank* the features that he perceived as vital to the system's operation; these models were then "tested" through in-depth discussions with nine widely recognized institution administrators and their key staff members (e.g., in-house counsel; head nurse; medical chief of staff; financial officer);
6) refine the models to develop a recommended system and analyze the mail questionnaire both manually and through the use of computerized equipment to complete the inventory of the systems that currently exist.

The key findings and conclusions that resulted from this research effort were that:

1) none of the systems now in existence have the authority to analyze, document and offer equitable settlement (either financial or medical) in malpractice situations;
2) many of these systems dealt with petty problems only and were perceived by other staff as being public relations functions;
3) no one staffing pattern was preferred;
4) few administrators had utilized the system as a conduit of information that would indicate needed changes in operations;
5) little systematic analysis as to the origin and reason for complaints has been undertaken;

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6) most physicians would accept only marginal interference from the patient grievance representative on the physician-patient relationships.

Three basic recommendations were developed as a result of the research that was conducted.

1) The time constraints imposed upon the Secretary's Commission on Medical Malpractice prevented the undertaking of the type of longitudinal in-depth cost/benefit analysis required to evaluate the existent systems. These analyses should be conducted.
2) The Federal government should underwrite the cost of several systems with varying features on a demonstration basis to determine which function most effectively in different environments.
3) A system should be developed that links the institutional office to a state office and to a Federal office (at the Regional and National level) if it is to be all-inclusive and impact on the continuum of consumers' complaints as well as the quality of health care provided.

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I. Introduction

BACKGROUND

This report is concerned with health care institutions (primarily hospitals) and the processes used to deal with all concerns of patients, from simple service problems to major incidents of medical malpractice.

Hospital administrators contend with the same kinds of problems that plague top managers of other large organizations. One of their most difficult problems is the remoteness and alienating aspect of hospitals as perceived by patients. In an effort to manage effectively, hospital management often overlooks the fact that "while hospital routine may be commonplace to hospital personnel, it is strange and mysterious to outsiders. Regulations granting visitors, mealtimes, treatment procedures, etc., often cause irritation and anxiety."[1] Also, most people enter hospitals fearing the events to follow, and this fact combined with the rising cost of a hospital stay puts the patient in a negative frame of mind.

A number of hospitals have sought to improve this continuum of patient care by designating an official, or office, to respond to patients' problems or complaints and, in effect, act as a "patient advocate" or ombudsman". This chapter of this report will set the stage for research findings on the present state of offices such as these and comparable organizations.

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[1] Editorial, "Community Relations for the Hospital Administrator," *Ross Laboratories,* Columbus, Ohio, Vol. 1, No. 3, July 1957.

The ombudsman in health care has been largely confined to an office or official concerned with patients and their problems or complaints within a health care institution. However, recently the Department of Health, Education and Welfare produced a report concerning ombudsmen in nursing homes which recommended a demonstration program, including national and state level ombudsmen.[2] Some governmental level ombudsmen adaptations have been established in the mental health area; for example,

- in New York State, the Benevolent Society for Retarded Children named two ombudsmen to be given access to buildings and records to protect the safety of retarded children
- in the Augusta (Maine) State Hospital, the Committee of Mental Health and Corrections has appointed a Patient Advocate
- in Milwaukee, Wisconsin, the Community Mental Health field education unit of the University of Wisconsin–Milwaukee School of Social Welfare—has designed and implemented an ombudsman position within the Milwaukee County Mental Health Center.

The kinds of health care ombudsmen of particular interest to the Secretary's Commission on Medical Malpractice are those offices established by hospitals to deal with patient complaints, problems, legal suits, etc. The American Hospital Association furnished the following job description of a "Patient Service Representative" and in a survey asked their membership whether they had a similar position.

> "A Patient Representative's primary assignment is to serve as management's direct representative to patients. As the liaison between patients and the institution, he provides a specific channel through which patients can seek solutions to problems, concerns, and unmet needs. As management's representative, he interprets the institution's philosophy, policies, procedures, and services to patients, their families, and visitors. As the patients' advocate, he enables patients and families to obtain solutions to problems by acting in their behalf with administration or any department of service, coordinating among departments if necessary, and recommending alternative policies and procedures in order to improve service to patients."

Four hundred sixty-two hospitals out of 1,000 responding reported that they had a similar position, but little was known about the nature of these offices, processes for handling complaints, types of complaints handled, organizational position of the office, and other details.

SCOPE AND METHODOLOGY

To fulfill the purpose and accomplish the objectives of this study, three separate data collection approaches were employed.

Mail Questionnaire

Questionnaires were sent to all AHA-registered hospitals with over 200 beds and to all Health Maintenance Organizations (HMO), and Office of Economic Opportunity-funded Neighborhood Health Centers (NHC). Hospitals with less than 200 beds were not surveyed because preliminary research indicated that smaller institutions were less likely to have formal PGMs because of funding limitations and because of the tendency for small hospital administrations to handle patient problems themselves. Also, the 200-beds-or-more sample of about 2,000 out of more than 7,000 AHA-registered hospitals was determined to be a manageable number for the resources of this study.

Health Maintenance Organizations were included because they represent an apparently emerging and significant means of health care delivery and because proposed legislation to aid in their development called for "meaningful procedures for hearing and resolving grievances . . . between enrollees and the Health Maintenance Organization. . . . "[3]

The principal reason for inclusion of Neighborhood Health Centers was that they represented a unique opportunity to view problems which involved poor and minority persons and to observe whether the problems and methods of resolution tended to differ from those serving the more affluent. Also considered was the fact that OEO has recently promulgated guidelines requiring that consumers constitute a majority of the Board of Directors of Neighborhood Health Centers.

However, our principal attention was devoted to hospitals, and a questionnaire (see Exhibit I) was designed to elicit quantitative characteristics and qualitative descriptions of those formal PGMs presently operational and to determine what procedures institutions without formal PGMs use to deal with patient complaints. The questionnaire was introduced with two cover letters, one from the SCMM, DHEW, and the other an endorsement from the American Hospital Association. A second copy of the questionnaire was mailed three weeks following the original mailing.

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[2] "Conceptual Bases and Analytical Framework for Modelling Investigative Ombudsman Units", prepared for the President's Nursing Home Program by the Subcommittee of the I-O Demonstration Program Work Group, Task Force on Investigative-Ombudsman Units, The President's Nursing Program, HSMHA, DHEW, January 28, 1972.

[3] U.S. Senate Bill S.3327, Section 1101 (D), March 13, 1972.

On-Site Interviews

The second method for data collection involved on-site visits to 16 hospitals, an HMO and a NHC which we known to have PGMs. The purposes of this step were to develop a case study of the operations of each PGM and to determine attitudes and personal views of institution personnel from many departments regarding the PGM. These responses included appraisals of weaknesses, strengths, and attitudes and suggestions for improvement. An evaluative approach to these visits was considered and discarded as being impractical since the time for the study was too short and no performance standards against which to evaluate systems existed for the PGMs in the institutions visited.

Since comprehensive information on existing PGMs was not available (this study is to provide it), selection of the institutions for on-site visits was a highly subjective process described as follows:

- Initially, the project team searched literature, talked with the AHA, talked with DHEW offices and interviewed Directors of PGMs in Philadelphia and New York City. This effort produced a list of about 50 names of institutions that were reported to have formal complaint mechanisms.
- Each of these institutions was sent a letter from the SCMM summarizing the study, informing them of a future telephone call from a study team member, and requesting cooperation.
- Using a brief checklist, calls were made to each of the institutions listed. The selection of the 18 systems was based on the receptiveness of the institution to a visit during the period of our study and whether, based on the preconception of PGMs in operation, the system appeared to be among the most relevant to the study. These decisions were partially intuitive, but the time and dollar constraints of the project made it impossible to undertake a more extensive review of the best PGM systems to visit.

  During these conversations information on other known PGMs was solicited and those institutions were added to the original sample.

For the on-site visits, an interview guide (see Exhibit II) was developed which was used to interview persons involved with a broad range of institution functions. Institutional data were collected and lengthy interviews were conducted with the head of the PGM to determine how the system worked and its strengths and weaknesses. Then, the consultants interviewed hospital staff, including doctors, nurses, public relations men, insurance representatives, lawyers and administrators to determine their involvement with the system, their views toward it and their suggestions for improving it.

The data collected from these two methods—mail questionnaire and personal interview—enabled the study team to isolate the elements of many types of patient grievance systems and to construct "model" PGMs (see Exhibits III through V). These models served as the subject of the final data collection process—model testing—that is described in the introduction of Chapter III of this report.

II. Research Findings

This chapter presents the quantitative data, the qualitative responses of persons interviewed, and conclusions drawn from these findings. Selected tables and personal interview responses that demonstrate the most significant findings will be incorporated in the text of this chapter. All of the tables processed from the mail survey and case write-ups of each personal interview have been included in the Technical Appendix of this report.

This Section is subdivided into the following categories of findings and conclusions:

- General characteristics of Patient Grievance Mechanisms in health care institutions
- Patient complaint processes in institutions without formal Patient Grievance Mechanisms
- Characteristics of formal patient grievance offices
- Elements of formal patient complaint systems
- Processes for dealing with all types of patient complaints.

GENERAL CHARACTERISTICS OF PATIENT GRIEVANCE MECHANISMS

From the sample of approximately 2,200 health care institutions, 280 returns indicated the existence of a "formal" patient complaint function (A respondents) and 770 indicated no formal mechanisms (B respondents).

Figure I on the following page diagrams the distribution of these returns by standard Federal region and shows the bulk of responses coming from the regions east of the Mississippi River with Region V being the most responsive.

As Table 1 below shows, "teaching" hospitals are more likely to have a formal patient complaint function. This table also indicates the low response received from a sample of about 200 Neighborhood Health Centers (funded by the Office of Economic Opportunity) and Health Maintenance Organizations. Many of these institutions replied that they were still in planning stages and not yet operational. Therefore, as Table 1 indicates, the data presented in this report will primarily apply to hospitals.

Figure I

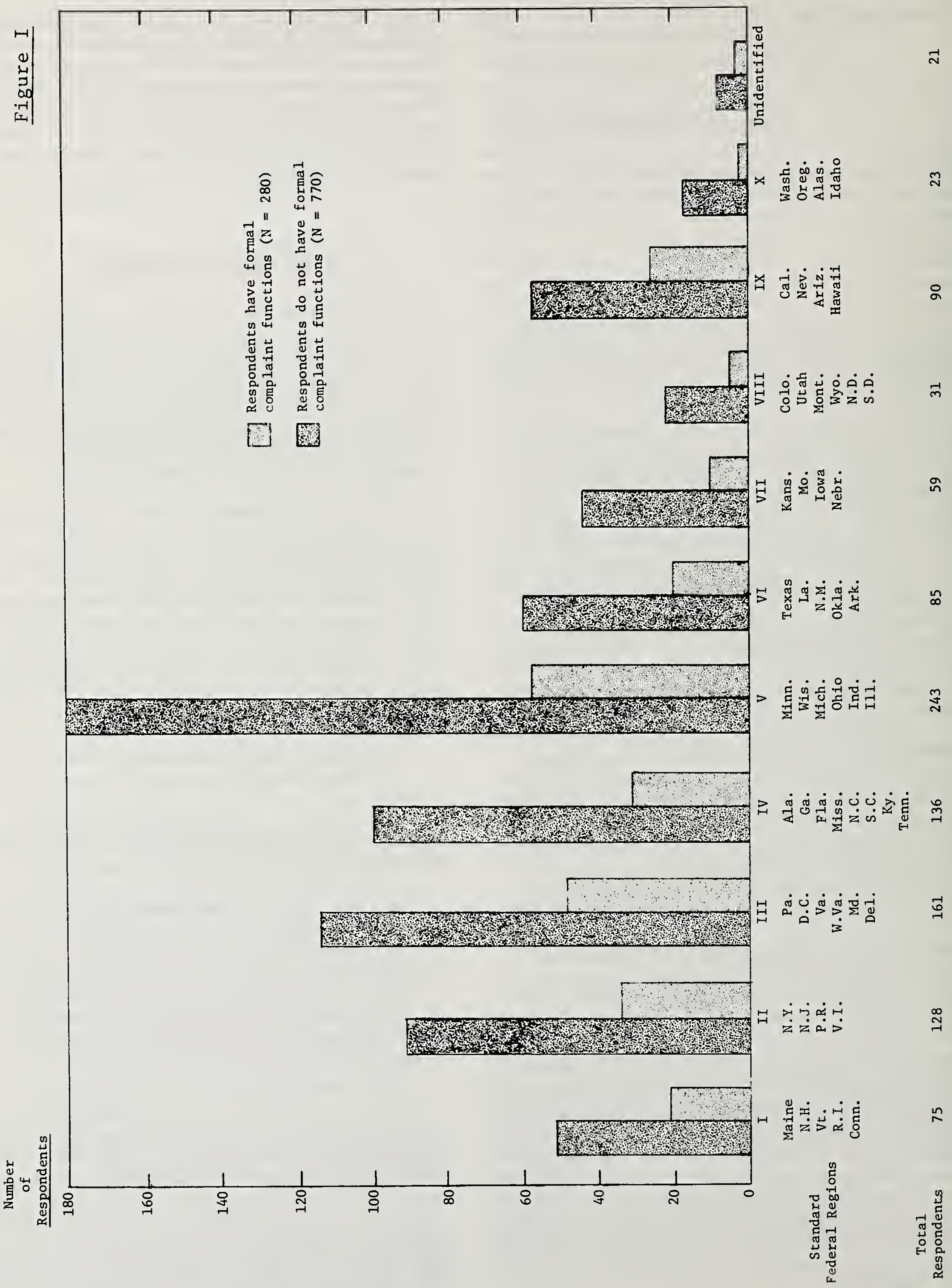
Number of Respondents
180
160
140
120
100
80
60
40
20
0
▨ Respondents have formal complaint functions (N = 280)
▩ Respondents do not have formal complaint functions (N = 770)
Standard Federal Regions
I Maine N.H. Vt. R.I. Conn.
II N.Y. N.J. P.R. V.I.
III Pa. D.C. Va. W.Va. Md. Del.
IV Ala. Ga. Fla. Miss. N.C. S.C. Ky. Tenn.
V Minn. Wis. Mich. Ohio Ind. Ill.
VI Texas La. N.M. Okla. Ark.
VII Kans. Mo. Iowa Nebr.
VIII Colo. Utah Mont. Wyo. N.D. S.D.
IX Cal. Nev. Ariz. Hawaii
X Wash. Oreg. Alas. Idaho
Unidentified
Total Respondents
75
128
161
136
243
85
59
31
90
23
21

TABLE 1
TYPES OF INSTITUTIONS RESPONDING

	Total A Respondents	Total B Respondents
	N=280	N=770
Hospitals (Teaching)	53.6	41.0
Hospitals (Non-teaching)	41.1	52.5
Health Center, Clinic, HMO, Nursing Home	2.9	1.4
Other than above	1.8	4.3
No Answer	0.7	0.8
TOTAL	100.1	100.0

Table 2 shows the breakdown of respondents by type of control. PGMs are more characteristic of non-Government, nonprofit organizations (64% compared to 34%). Other-operated nonprofit hospitals are more likely to have formal PGMs than any other category of institution shown in the table (43%).

TABLE 2
TYPE OF INSTITUTION CONTROL

	Total A Respondents	Total B Respondents
	N=280	N=770
NON-GOVERNMENT		
Nonprofit		
Church operated	20.4	20.8
Other operated	43.2	34.6
TOTAL	63.6	55.4
For Profit	2.8	2.0
GOVERNMENT, NON-FEDERAL		
State	11.8	17.8
County	6.4	5.7
Other	2.6	5.5
GOVERNMENT, FEDERAL		
Armed Forces	6.0	1.2
Veterans Admin.	5.0	11.6
Other	1.8	0.8
TOTAL (Gov't.)	33.6	42.6
TOTAL	100.0	100.0

The breakdown of respondents by number of beds is diagrammed in Figure II. The percent of A and B respondents is not significantly different for all size categories except 200-299 beds. For this category 32% were B respondents compared with 25% A respondents. This difference supports the assumption underlying the exclusion of hospitals with less than 200 beds from the survey sample. That is, small hospitals do not have formal complaint mechanisms because top administration is close enough to patients and hospital operations to deal with patient complaints itself.

Figure III compares the number of annual admissions of both respondent groups. The percent of A respondents (13%) with under 5,000 admissions per year is significantly lower than the 23% of B respondents. Tables 3 and 4 show that hospitals with low annual admissions are not usually general medical and surgical, and most psychiatric respondents have low yearly admissions. Approximately one-third of Government A respondents have under 5,000 admissions, compared with almost one-half of Government-controlled B respondents.

To complete a general description of the respondent population, approximately two-thirds of both A and B respondents treated 75% or more of their patients in less than 30 days, indicating that most respondents are "short-term stay" institutions (as defined by the AHA). Most hospitals with formal complaint functions classified the service provided to a majority of their patients as general medical and/or surgical.

Table 5 presents the respondents' own rating of the procedure(s) used to resolve patient complaints in their institutions. Just over one-half of all respondents rated themselves "good", but significantly more A respondents (33%) than B respondents (22%) considered the procedures of their institutions "excellent".

PATIENT COMPLAINT PROCESSES IN INSTITUTIONS WITHOUT FORMAL PATIENT GRIEVANCE MECHANISMS

Institutions which did not have a person or function formally designated to resolve patient complaints were asked to describe how they dealt with four types of complaints: (1) Contact, (2) Financial, (3) Malpractice, and (4) Other. The responses to these four categories are analyzed below. This analysis presents the major themes or types of responses made by B respondents in describing what their institutions do to resolve patient complaints.

Contact Complaints

Contact complaints, according to responses, are ordinarily handled either (1) by the person receiving them, with some notion of appeal to, or involvement of, higher authority if that person cannot satisfactorily resolve them, or (2) by direct involvement of supervisory staff or "administration". Examples of typical responses include:

- "Complaints are filed with the personnel in the area involved. If it cannot be resolved at that level, the matter is referred to the assistant administrator. If he is unable to resolve it, it is reported to the administrator."

(Nonprofit hospital, 300-399 beds, New Jersey)

Figure II

DISTRIBUTION OF RESPONDENTS BY SIZE
(Number of Beds)

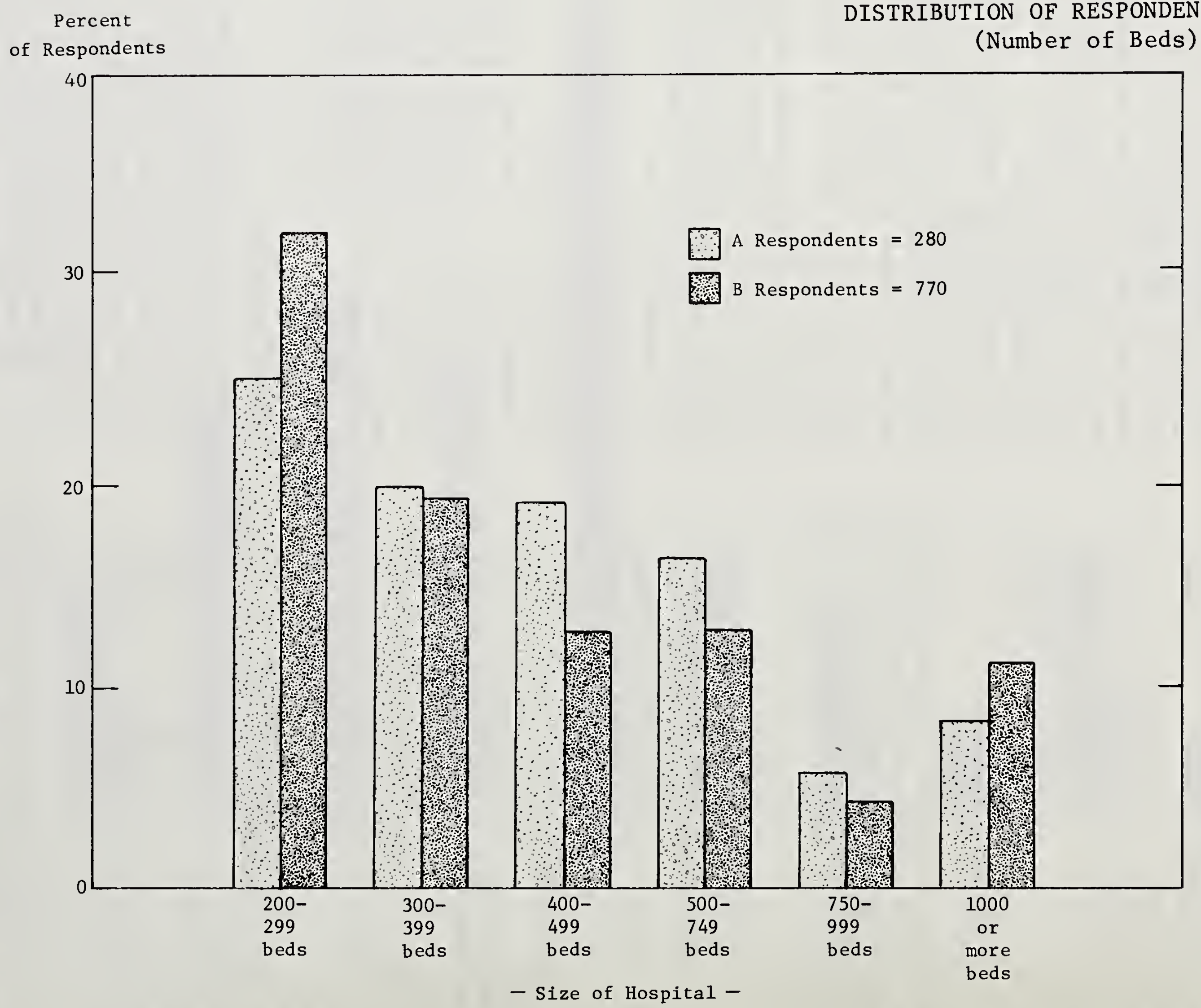

Figure III

DISTRIBUTION OF RESPONDENTS BY
NUMBER OF ACTUAL ADMISSIONS

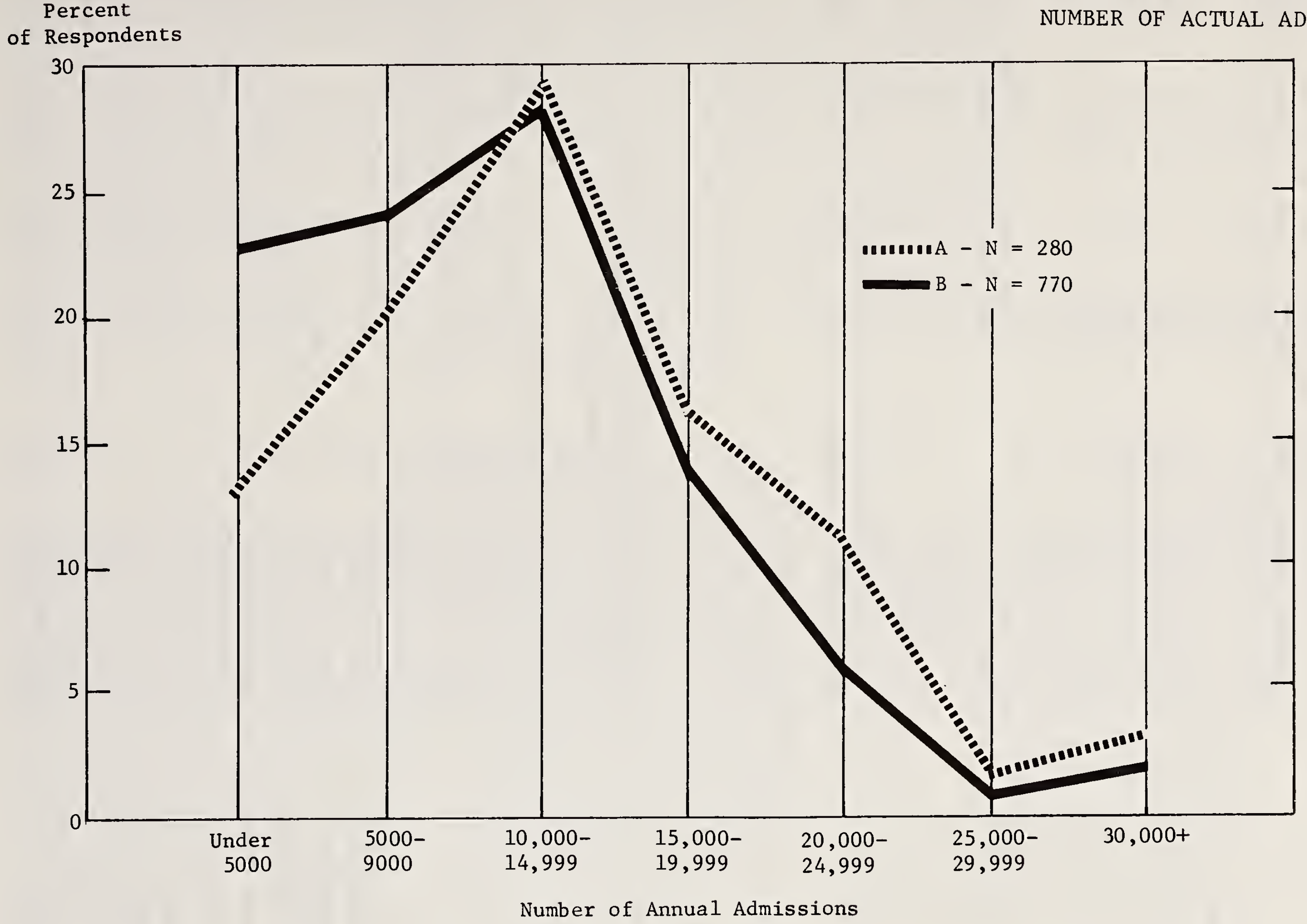

TABLE 3
NUMBER OF ADMISSIONS OVER A 12-MONTH PERIOD
A RESPONDENTS

		Type of Control				Type of Service		
	Total	Gov't N-Fed	Gov't Fed	Non-Proft	Proft	Gen Med	Psych	Other
	N=280	N=58	N=36	N=178	N=8	N=239	N=25	N=16
None								
Under 5,000	12.9	39.7	33.3	0.6		2.5	88.0	50.0
5,000-9,000	19.6	8.6	27.8	20.8	37.5	21.8	12.0	
10,000-14,999	28.6	24.1	16.7	32.0	37.5	32.6		12.5
15,000-19,999	16.1	6.9	5.6	21.9		18.8		
20,000-24,999	11.1	5.2	8.3	14.0		12.6		6.3
25,000-29,999	2.5			3.9		2.9		
30,000 or more	3.2	5.2		3.4		3.8		
No answer	2.5	3.4	2.8	2.2		2.9		
*Not a hospital	3.6	6.9	5.6	1.1	25.0	2.1		31.3
TOTAL	100.1	100.0	100.1	99.9	100.0	100.0	100.0	100.1

TABLE 4
NUMBER OF ADMISSIONS OVER A 12-MONTH PERIOD
B RESPONDENTS

		Type of Control				Type of Service		
	Total	Gov't N-Fed	Gov't Fed	Non-Proft	Proft	Gen Med	Psych	Other
	N=770	N=223	N=104	N=427	N=16	N=604	N=103	N=61
None	0.4	1.3					1.0	3.3
Under 5,000	22.6	54.7	41.3	1.9	6.3	6.0	88.4	77.1
5,000-9,000	23.5	8.1	43.3	26.5	31.3	29.0	4.9	1.6
10,000-14,999	27.7	18.8	8.7	36.5	37.5	34.9	1.0	1.6
15,000-19,999	14.2	7.6	2.9	20.4	12.5	17.7	1.0	
20,000-24,999	5.7	1.8		9.1	6.3	7.0	1.0	1.6
25,000-29,999	1.3	1.3		1.6		1.7		
30,000 or more	1.8	1.3		2.3	6.3	2.3		
No answer	0.6	0.9	1.9	0.2		0.7	1.0	
*Not a hospital	2.2	4.0	1.9	1.4		0.8	1.9	14.8
TOTAL	100.0	99.8	100.0	99.9	100.2	100.1	100.2	100.0

TABLE 5
RATING OF PROCEDURES USED TO RESOLVE PATIENT COMPLAINTS

	Total A Respondents	Total B Respondents
	N=280	N=770
Excellent	32.9	22.1
Good	51.1	50.8
Average	11.8	22.1
Fair	2.1	2.3
Poor	0	1.2
No Answer	2.1	1.6
TOTAL	100.0	100.0

- "Complaint is handled by department head of department involved and a report is given to administration. If further action is indicated, administration initiates it."
  (Church-operated hospital, 700-799 beds, Hawaii)
- "1st level: 'Charge' nurse or person or nursing unit or service department
  2nd level: Nursing service supervisor (all shifts)
  3rd level: Administration."
  (City hospital, 200-299 beds, Massachusetts)

About 5% of the institutions report "exit" or "follow-up" questionnaires or some other means of complaint receipt or handling process. Exit questionnaires are ordinarily reviewed by the administrator or his assistants, and in a few cases are forwarded to a "Patient Care Committee" in the hospital. Some typical illustrations of questionnaire user responses are:

- "In our institution, we have a patient opinion form that is given to the patient upon discharge. These are received by the Assistant Administrator for Patient Care, who reviews them immediately."
  (Nonprofit hospital, 500-749 beds, Arizona)
- "We have an exit questionnaire which is given all patients. . . . "
  (Nonprofit hospital, 300-399 beds, Florida)
- "Every patient is given a 'Patient Care Evaluation' questionnaire upon discharge to complete and return to the hospital."
  (Nonprofit hospital, 200-299 beds, New Jersey)
- "Have used an outside consulting firm to perform an attitude survey of patients. . . . "
  (County hospital, 750-999 beds, Georgia)
- "A Humane Practices Committee also conducts patient attitude surveys and discusses results with administrator."
  (State hospital, over 1,000 beds, Minnesota)

In psychiatric insititutions there is apparently some tendency to set up patient committees which review complaints and attempt to resolve them in dealings with the staff. One institution described this procedure by saying "Complaints are brought to attention of patient-elected representatives and staff advisors who comprise the Central Steering Committee of the Patient Participation Program."

Financial Complaints

Financial complaints, in most cases, are handled by the accounting or financial department, with the administrator or his assistants handling such complaints when resolution is not easily achieved or where the complaint was initially registered with them. Typical responses to this category are:

- "Financial Complaints are handled by the Manager of Credit Collections or some other designated Business Office employee."
  (County hospital, 300-399 beds, Texas)
- "1. Business Office Patient Accounts Man.
  2. Controller
  3. Administrator
  (Church hospital, 200-299 beds, Wisc.)

Malpractice Complaints

The responses to this category indicated that malpractice complaints were handled by either the adminstrator or administrative staff, the insurance carrier or hospital lawyers or any combination of the three. Several responses also indicated that the hospital did not handle these complaints as such since they ordinarily came in the form of a notification from an attorney and were directed to the insurance carrier. Hence, most institution staff handle only less severe complaints and, in some rare cases, reassure patients that malpractice has not occurred. Those more severe complaints (i.e., malpractice) are not handled by hospital staff or administration when a settlement might be warranted. This is the purview of insurance carriers and their lawyers.

Some responses indicative of processes followed to handle malpractice complaints are:

- "Any complaint regarding an attending physician would be referred to the director of medical service who . . . would transmit his recommendations to administration. Where an incident report is indicated, the information is transmitted to the insurance company."
  (Nonprofit hospital, 200-299 beds, New York)
- "Complaints alleging malpractice of a hospital employee are referred to the Administrator, who makes a thorough investigation of the alleged malpractice. Those of a medical staff nature are referred to the chief of the medical staff."
  (District hospital, 200-299 beds, Florida)

- "Most situations which are potential malpractice cases are brought to the attention of the Administration in the form of an incident report. . . . The hospital's insurance carrier is notified of all potential liability cases by a copy of the report."
  (District hospital, 500-799 beds, Florida)

- "Handled directly by Administrator . . . with following:
  a) hospital attorney
  b) Chief of medical staff
  c) Chairman of Board
  d) interested parties."
  (Church-operated hospital, 200-299 beds, Missouri)

A few hospitals reported a medical evaluation process and possible disciplinary action, but it appears that, for the most part, such evaluations are only to provide advice to the insurance carrier or lawyer. Responses demonstrating this procedure include:

- "A committee of three physicians from adjoining communities would be consulted concerning the validity of the complaints."
  (State hospital, 300-399 beds, New Mexico)

- "The Administrator investigates with Chief of Service and President of Medical Staff, and cases requiring disciplinary action are brought before the Medical Executive Committee."
  (Nonprofit hospital, 200-299 beds, Massachusetts)

- "[Complaints] referred to Medical Staff Committee for peer review. Complainant advised of right to choose another physician or ask for consultation."
  (Church-controlled hospital, 200-299 beds, Wisconsin)

- "A panel of three staff doctors is called together to go over the case. If it is found the doctor is wrong, it is turned over to the Hospital Solicitor. If the doctor is found to be right the patient is informed by the Committee."
  (Unidentified)

Other Complaints

Very few respondents actually had specific "other" complaints in mind and simply failed to complete the category, or referred to their descriptions of contact complaints. Unique "other" complaint subjects included Congressional complaints reported by a Veterans Administration Hospital, interdepartmental or employee grievances, racial discrimination, and safety and security problems. One hospital reported that the "only other complaints . . . are those involving the grounds of the hospital—lighting and some instances of uncut weeds."

In conclusion, almost all health care institutions indicated that they receive patient complaints and have some means of dealing with them. With only a few exceptions, institutions without formal functions or persons assigned to handle complaints indicated a vaguely defined process for complaint resolution, in which complaints are handled principally by those who receive them, except for malpractice, which is passed on to the administrator and from him to the insurance carrier and/or legal staff.

Institutions with Discontinued Patient Complaint Function

Seventeen institutions reported that they had had a formal patient complaint function and had discontinued it. Responses from these institutions produced no particular pattern and were too brief for useful analysis. The most frequently stated reason for discontinuance pertained to funds availability, but a few suggested that lack of control or emphasis on patient rights was the reason. Illustrations of responses include:

- "Approximately eight months ago an Ambassador Service (Ombudsman idea) was instituted. Trial data was gathered and analyzed. . . . A full-time Ambassador could not be dollar justified. . . . "
  (Nonprofit hospital, 400-499 beds, Pennsylvania)

- "1. Expense
  2. Lack of desired results
  3. Loss of control (become more attuned to patient problems than with hospital needs, rules, etc.)"
  (Church hospital, 500-749 beds, Michigan)

- "Hospital management felt that all complaints should be resolved by manager accountable for the work being performed."
  (Nonprofit hospital, 400-499 beds, Nebraska)

- "Patient Representative position discontinued in 1971 because of budgetary considerations."
  (Nonprofit hospital, 300-399 beds, New Jersey)

A few institutions indicated that while they did not have a formal function, they were about to initiate one. None supplied enough information for us to be able to gain an understanding of their prospective program or specific reasons for initiating it.

Characteristics of Formal Patient Grievance Offices

This report section presents a "composite picture" of formal patient grievance offices presently existing in hospitals.

Creation of Patient Grievance Mechanisms

The Patient Grievance Mechanisms (PGM) studied are designed to accomplish unique sets of objectives, and most evolved from unique forces coming to play on health care institution administrations. The first chapter of this report presents an appraisal of the general atmosphere for increased consumer awareness and involvement in decision making, and the creation of a number of the PGMs studied can be attributed in part to this increase in consumer activism. Based on the on-site personal interviews with an eye to quantitative questionnaire data, other factors, discussed below, were found to influence administration decisions to create PGMs.

- *Loss of charitable immunity made many hospitals vulnerable to legal suits.* As a hedge against possible "vengeance" suits resulting from poor service in hospitals, some organizations set up offices to give special attention to patient problems as they happen and to make sure that any potential liability problem is brought to the attention of top administration for immediate consideration.

  For example, NEH hospital[4] did not create a new office of patient complaints but instead assigned this complaint resolution responsibility to the Associate Administrator for Impatient Services. This office is advertised to patients as the "ombudsman for the patient" and sees that all patient concerns are given proper attention.

- *Some institutions replaced (or supplemented) post-stay questionnaires with internal PGMs to solicit complaints and evaluate the patient's attitudes while the patient is in the hospital.* Since these data were collected after the fact and were often not identified with a particular patient, it was difficult to appease the complainant. Therefore, some patient complaint functions were created to receive comments directly from patients during their involvement with the institutions. In this way, latent dissatisfactions could be surfaced and resolved to keep the patient in a positive frame of mind ("nuisance" malpractice suits often stem from simple patient dissatisfactions with nonmedical services).

  CLM Hospital has a "Patient Relations Department" staffed by eight women described as "airline stewardess types". These women encourage patients to voice complaints by visiting them and discussing hospital and/or medical services. They also greet new admissions and try to set the usually disturbed person at ease.

  AMH Hospital changed from a post-stay questionnaire to a volunteer interviewer who visited patients and administered an open-ended questionnaire. This function achieved organizational status as the "Patient Interviewing Committee" and now has a full-time director and five volunteer interviewers.

- *Large hospitals studied (750 or more beds) created PGMs, in part, to provide an office that "troubleshoots" the many separate systems operating in hospitals.* The functions were designed to provide an office that observes the interface between subsystems and recommends procedural changes.

  For instance, MSM hospital has a large outpatient department (110 clinics) and many problems resulting from patients (without private physicians) waiting long periods of time for treatment, especially if they had to attend more than one clinic. The Patient Relations Department studied these problems and recommended and helped institute a system that provided individual attention to each patient. Whenever a patient was delayed or misdirected he could call on a central patient relations desk for assistance. Also, the method for receiving prescriptions from the pharmacy caused many patients to wait an hour only to find out that their prescription needed another authorization signature. The Department studied this systematic bottleneck and recommended elimination of one step in the approval process and revision of the hours the pharmacy was open to fill prescriptions.

- *In some hospital studied PGMs were created to reduce patient dissatisfaction with the admissions procedures.* The Admissions Office is often impersonal, requiring extensive administrative information prior to admittance, and in some cases causing patients to wait long periods of time before assignment of rooms. CLM hospital's Patient Relations Department has as a primary responsibility providing continuous individualized attention to each patient from admission to discharge (and sometimes follow-up assistance). The Patient Representative helps with completion of forms, escorts the patient to his bed, visits him periodically during this stay and addresses himself to all concerns the patient has.

- *Some hospitals created a Patient Representative to improve public relations with "VIP" patients and particularly those who support the institution financially.* At one large urban-based hospital studied, the Patient Representative spent most of her time with prominent celebrities admitted to this hospital, providing "services they could expect from any high-priced hotel." As she progressed in this job, this PR broadened her scope to include investigation of complaints of possible negligence and is becoming more of a voice for all patients. The hospital is also questioning the value of her function and may choose to discontinue the program. In general, most institutions visited having Patient Representatives, Patient Relations Departments and Hostesses justified the cost of the functions as necessary public relations expense, and since most of these institutions have a large number of affluent clients, one concludes that public relations is an important part of fund raising.

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[4] Since hospitals interviewed were promised anonymity, case study hospitals are identified by three-letter combinations.

- *Some hospitals studied formed Patient Grievance Mechanisms for the purpose of improving community relations.* Specifically, two hospitals visited are located in urban areas populated mostly by lower-income minority people who do not usually have private physicians and depend on the hospital for health care services. These institutions have "Community Representatives" stationed in the outpatient clinics and the emergency rooms. These offices are staffed by indigenous persons who can communicate effectively with the community people (one was formerly with the local Community Action Agency). To demonstrate the need for this position one respondent indicated that doctors (usually house staff) and nurses in the emergency room are prepared to give medical treatment to a wounded victim of a gang fight, but are *not* prepared to put the rest of his gang at ease while their "brother" is being treated.
  Also, lower income and poor people tend to regard institutions as forbidding and therefore do not seek out the health care they need. Having a Community "Ombudsman" stationed in the OPD and/or emergency room demonstrates the hospital's willingness to serve the community.

- *Two hospitals visited formed offices to deal with liability and potential malpractice cases.* These institutions have high deductible insurance policies making them partially self-insured. Therefore, it is in the best financial interest of these hospitals to have an office that studies all potential cases and, in conjunction with the insurance carrier, determines the proper course of action to avoid suits and settle claims. JHH Hospital has an in-house attorney that performs this function. One preventative process this office employs is to review all large billings before invoices are sent to patients. If there are any medical incidents (medication misdosages, falls etc.) associated with these cases, there is a high probability that large bills will provoke lawsuits and the JHH attorney recommends approaches for settling these bills designed to make the patient happy and to reduce the probability of suit.

Characteristics of Persons in Charge of Patient Complaint Functions

Of the 280 institutions claiming to have a specific person designated as in charge of patient complaints, about 33% report titles deriving from the concept of patient services or "Patient Representation" (see Table 6). Table 7 lists the large variety of titles stated. The title "Director of Patient Relations" is reported three times as often as the next most frequently reported titles, i.e., "Director of Patient Service", "Coordinator of Patient Services" and "Patient Service Representative". Table 6 shows that about 38% report an "administrative" title, i.e., a top management, top medical or an assistant to top management title. In addition, 20% report a "Public and/or Community Relations" title. Just under ten percent report a variety of other titles; only two titles are reported three or more times: "Director of Social Services" and "Project Director".

Table 8 breaks out the distribution of respondent office head titles by standard Federal region and shows that the western region (including California) makes a relatively higher use of the "Patient Complaint function" title than New England, South Central or Mid-Central. Despite this difference, this table shows relatively even distribution of titles. About one-third of titles used in the North Central region are in the "Public/Community Relations" category. This may be attributed to the highly urban, densely populated nature of the region, requiring hospitals to create functions designed to keep the institutions in touch with their consumers, particularly those from the immediate urban (often low income) neighborhoods.

Table 6 also shows that the Federal Government-controlled hospitals make significantly greater use (64%) of administrative titles than do nonprofit or non-Federal Government-controlled institutions. Also, this table shows most of the public/community relations titles reported coming from the nongovernment, nonprofit hospitals.

Those giving a patient complaint job title are more likely to be earning salaries under $15,000 per year and those giving administrative titles are more likely to be earning $15,000 or more per year, as shown in Table 6.

Further detail on salaries is given in Table 9 which shows that half of those with patient complaint titles report earning less than $10,000 compared to almost half of those with administrative titles earning $20,000 or more. Both public and/or community relations and miscellaneous titles also tend to report higher earnings than those with patient complaint function titles. Table 9 also shows that those respondents earning the least are least likely to have other professionals working for them and least likely to have additional hospital responsibilities. That is, they are most

TABLE 6
TITLE OF PERSON IN CHARGE OF PATIENT COMPLAINT FUNCTION
A RESPONDENTS

		Salary		Level of Reporting			Number of Staff			Type of Control			
	Total	Under 15000	15000 & Ovr	First	Secnd	Third	1 FT Prof	1 PT Prof	Mult Profs	Gov't N-Fed	Gov't Fed	Non-Proft	Proft
	N=280	N=156	N=110	N=201	N=49	N=19	N=109	N=80	N=91	N=58	N=36	N=178	N=8
Patient Complaint Function Titles	32.9	51.3	6.4	26.4	57.1	47.4	48.6	16.3	28.6	36.2	27.8	32.6	37.5
Administrative Titles	37.5	15.4	68.2	42.3	20.4	21.1	24.8	50.0	41.8	36.2	63.9	33.1	25.0
Public/Community Relations Titles	20.0	20.5	20.0	20.9	16.3	15.8	18.3	27.5	15.4	8.6	2.8	27.5	12.5
Miscellaneous Titles	9.6	12.8	5.5	10.4	6.1	15.8	8.3	6.3	14.3	19.0	5.6	6.7	25.0
No Answer													
TOTAL	100.0	100.0	100.1	100.0	99.9	100.1	100.0	100.1	100.1	100.0	100.1	99.9	100.0

TABLE 7
TITLES OF FORMAL PATIENT COMPLAINT FUNCTIONS LISTED FIVE OR MORE TIMES

Title	Number of Times Mentioned
Assistant (to) Administrator	30
Director of Public Relations	29
Administrator	19
Director—Patient Relations	15
Director—Community Relations	11
Assistant (to) Director	8
Patient Representative	8
Director	6
Chief Medical Administrative Service	6
Patient Service Representative	6
Director Social Service	5
Director Patient Service	5
Coordinator Patient Service	5
Hostess	5
Patient Advocate	5
Ombudsman	5
Other titles mentioned less than five times	112
TOTAL	280

likely to be full time in patient complaints and to be the only such per so designated. Also, those earning less than $15,000 are most likely to be in non-Federal Government or nonprofit insitutions.

Table 10 shows that about 58% of those with patient complaint function titles report to the first (or highest) level of management compared to 75% or more of the titles in the other three categories. This difference is shown also in Table 6 under "level of reporting" where only 26% of those respondents reporting to the first management level have patient complaint function titles. This table also shows that size of salary is not directly proportional to levels of reporting since about 80% of those making the highest salaries and over two-thirds of those respondents with salaries below $15,000 report to the first level of management.

Table 11 shows the age, race and sex of persons in charge of patient complaint functions. About 58% are over age 45 and 92% are white. About 57% are men, and men dominated the administrative titles and higher salaries while patient complaint function titles and lower salaries apply primarily to women. Almost two-thirds of those reporting to the first level of management are men compared to the almost two-thirds of those reporting to the second level who are women. The distribution is more equitable among those reporting to the third level of management.

Table 12 shows that those who indicate only one part-time person, or multiple persons, in the patient complaint function are more likely to be men, while women are more likely to indicate only one full-time professional (themselves). As suggested by Table 6 as well as Table 12, those with administrative titles are likely to be men who handle patient complaints as part of their overall duties while those with patient complaint titles are likely to be women whose function is primarily handling patient complaints. As noted elsewhere, the organizational position or status of these two-administrators and patient complaints titles—is quite different in terms of reporting level and salary.

Finally, men, more often than women, are located in government institutions (Federal and non-Federal), but both sexes are found about equally often in nonprofit and for-profit institutions.

In the main, those in charge of patient complaint functions are well educated. As shown in the "Total" column of Table 13, about 63% have bachelor's, master's or "other" degrees. These "other" degrees are primarily medical doctors or masters of hospital administration who declined to classify themselves under the unspecified "master's degree" classification. About 46% of those with administrative titles have master's degrees and about 41% of those with public and/or community relations titles have bachelor's degrees. Those with patient complaint titles are more evenly distributed among the various levels of training, and salary levels and reporting levels are consistent with level of education.

Table 14 shows the study area of the highest level of education. Nursing predominates among the patient complaint titles, medicine, business, liberal arts and "other" among administrative titles. Liberal arts predominates as the area of study among those with public and/or community relations titles. "Other" study areas written in by respondents included:

- Theology
- Engineering
- Journalism
- Economics
- Paramedical (Army)
- Counseling
- Psychology/Psychiatry
- Advertising and Marketingg.

Table 15 shows that just less than half of patient complaint titles had prior work experience in nursing, significantly higher than for other titles. Almost two-thirds of administrative titles had prior experience in health care administration.

Table 15 also shows the prior work experience of those in charge of patient complaint functions cross-tabulated with highest level of education. About 65% of those with master's degrees have prior work experience in health care administration as did about 23% of those with "other" degrees. From eight percent to 25% of those with other levels of education have prior work experience in nursing in addition to those with nursing diplomas. Those with prior work experience in social work are not concentrated in the professional degree levels (bachelor's and master's), but are evenly spread among the various levels of education. A fairly even distribution among levels of education is also found among those whose prior work experience was in personnel. Office work, however, is more likely to have

TABLE 8
TITLE OF PERSON IN CHARGE OF PATIENT COMPLAINT FUNCTION
A RESPONDENTS

		Region										
	Total	New Eng	NY,NJ	Mid Atl	South	No Centl	So Centl	Mid Centl	Near West	West	No West	Un-Ident
	N=280	N=21	N=37	N=47	N=32	N=60	N=22	N=14	N=8	N=30	N=2	N=7
Patient Complaint Function Titles	32.9	23.9	43.2	34.0	34.4	31.7	22.7	14.3	25.0	50.0		14.3
Administrative Titles	37.5	42.9	32.4	42.6	43.8	25.0	50.0	28.6	50.0	40.0	50.0	42.9
Public/Community Relations Titles	20.0	23.8	21.6	14.9	15.6	33.3	9.1	21.4	12.5	6.7		42.9
Miscellaneous Titles	9.6	9.5	2.7	8.5	6.3	10.0	18.2	35.7	12.5	3.3		50.0
No Answer												
TOTAL	100.0	100.0	99.9	100.0	100.1	100.0	100.0	100.0	100.0	100.0	100.0	100.1

TABLE 9
SALARY RANGE OF PATIENT COMPLAINT FUNCTION DIRECTOR
A RESPONDENTS

		Job Title				No. of Staff			Type of Control			
	Total	Pat Comp	Admin	PB/CM Relat	Misc	1 FT Prof	1 PT Prof	Mult Profs	Gov't N-Fed	Gov't Fed	Non-Proft	Proft
	N=280	N=92	N=105	N=56	N=27	N=109	N=80	N=91	N=58	N=36	N=178	N=8
Below $10,000	23.9	50.0	6.7	12.5	25.9	38.5	10.0	18.7	34.5	5.6	24.2	25.0
$10,000-14,999	31.8	37.0	16.2	44.6	48.2	34.9	31.3	28.6	27.6	16.7	35.4	50.0
$15,000-19,999	18.9	7.6	22.9	32.1	14.8	13.8	28.8	16.5	10.3	36.1	19.1	
$20,000 and over	20.4		48.6	7.1	7.4	11.0	25.0	27.5	25.9	36.1	15.2	25.0
No Answer	5.0	5.4	5.7	3.6	3.7	1.8	5.0	8.3	1.7	5.6	6.2	
TOTAL	100.0	100.0	100.1	99.9	100.0	100.0	100.1	100.1	100.0	100.1	100.1	100.0

TABLE 10
REPORTING LEVEL OF PERSON IN CHARGE OF PATIENT COMPLAINT FUNCTION

		Job Title				Salary	
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr
	N=280	N=92	N=105	N=56	N=27	N=156	N=110
First	71.8	57.6	81.0	75.0	77.8	68.6	79.1
Second	17.5	30.4	9.5	14.3	11.1	22.4	10.0
Third	6.8	9.8	3.8	5.4	11.1	7.1	6.4
No Answer	3.9	2.2	5.7	5.4		1.9	4.5
TOTAL	100.0	100.0	100.0	100.1	100.0	100.0	100.0

TABLE 11
DESCRIPTION OF PERSON IN CHARGE OF PATIENT COMPLAINT FUNCTION

		Job Title				Salary		Level of Reporting		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Secnd	Third
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19
AGE										
Under 30	11.4	10.9	14.3	8.9	7.4	13.5	8.2	13.9	2.0	10.5
31-45	29.6	22.8	31.4	32.1	40.7	26.9	32.7	28.4	26.5	36.8
Over 45	58.2	65.2	53.3	58.9	51.9	58.3	59.1	56.7	71.4	52.6
No Answer	0.7	1.1	1.0			1.3		1.0		
TOTAL	99.9	100.0	100.0	99.9	100.0	100.0	100.0	100.0	99.9	99.9
RACE										
White	91.8	90.2	91.4	96.4	88.9	91.7	90.9	90.5	100.0	89.5
Black	4.6	6.5	2.9	1.8	11.1	5.8	3.6	5.5		10.5
Other	0.7		1.9				1.8	1.0		
No Answer	2.9	3.3	3.8	1.8		2.6	3.6	3.0		
TOTAL	100.0	100.0	100.0	100.0	100.0	100.1	99.9	100.0	100.0	100.0
SEX										
Male	57.1	23.9	83.8	58.9	63.0	35.3	89.1	63.7	34.7	47.4
Female	40.4	72.8	13.3	39.3	37.0	62.2	9.1	34.3	65.3	52.6
No Answer	2.5	3.3	2.9	1.8		2.6	1.8	2.0		
TOTAL	100.0	100.0	100.0	100.0	100.0	100.1	100.0	100.0	100.0	100.0

TABLE 12
DESCRIPTION OF PERSON IN CHARGE OF PATIENT COMPLAINT FUNCTION
A RESPONDENTS

		Type of Control				No. of Staff		
	Total	Gov't N-Fed	Gov't Fed	Non-Proft	Proft	1 FT Prof	1 PT Prof	Mult Profs
	N=280	N=58	N=36	N=178	N=8	N=109	N=80	N=91
AGE								
Under 30	11.4	13.8	5.16	12.4		11.9	13.8	8.8
31-45	29.6	27.6	36.1	28.1	50.0	21.1	31.3	38.5
Over 45	58.2	56.9	58.3	59.0	50.0	65.1	55.0	52.7
No answer	0.7	1.7		0.6		1.8		
TOTAL	99.9	100.0	100.0	100.1	100.0	99.9	100.1	100.0
RACE								
White	91.8	81.0	91.7	94.9	100.0	89.9	95.0	91.2
Black	4.6	13.8	2.8	2.2		6.4	3.8	3.3
Other	0.7	1.7	2.8					2.2
No answer	2.9	3.4	2.8	2.8		3.7	1.3	3.3
TOTAL	100.0	99.9	100.1	99.9	100.0	100.0	100.1	100.0
SEX								
Male	57.1	63.8	91.7	48.3	50.0	42.2	71.3	62.6
Female	40.4	32.8	5.6	49.4	50.0	55.0	26.3	35.2
No answer	2.5	3.4	2.8	2.2		2.8	2.5	2.2
TOTAL	100.0	100.0	100.1	99.9	100.0	100.0	100.1	100.0

TABLE 13
HIGHEST LEVEL OF EDUCATION OF PERSON IN CHARGE OF PATIENT COMPLAINT FUNCTION
A RESPONDENTS

		Job Title				Salary		Level of Reporting			No. of Staff		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Secnd	Third	1 FT Prof	1 PT Prof	Mult Profs
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19	N=109	N=80	N=91
Below High School Grad													
High School Graduate	4.3	10.9		3.6		5.8	1.8	4.5	4.1	5.3	5.5		6.6
Some Training Beyond High School	20.4	27.2	7.6	30.4	25.9	29.5	7.3	18.4	28.6	26.3	28.4	16.3	14.3
Associate Degree	3.2	4.3	1.0	1.8	11.1	3.8	1.8	2.5	6.1	5.3	2.8	2.5	4.4
Nursing Diploma	6.8	19.6	1.0			11.5	0.9	5.0	12.2	15.8	10.1	3.8	5.5
Bachelors Degree	25.7	20.7	21.0	41.1	29.6	30.1	20.9	25.4	32.7	15.8	27.5	25.0	24.2
Masters Degree	27.1	10.9	45.7	17.9	29.6	14.1	44.5	30.8	12.2	15.8	19.3	32.5	31.9
Other Degree	10.7	6.5	19.0	5.4	3.7	3.8	20.9	11.4	4.1	15.8	4.6	18.8	11.0
No Answer	1.8		4.8			1.3	1.8	2.0			1.8	1.3	2.2
TOTAL	100.0	100.1	100.1	100.2	99.9	99.9	99.9	100.0	100.0	100.1	100.0	100.2	100.1

TABLE 14
STUDY AREA OF HIGHEST LEVEL OF EDUCATION OF PERSON IN CHARGE OF PATIENT COMPLAINT FUNCTION

		Job Title				Salary		Level of Reporting			No. of Staff		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Secnd	Third	1 FT Prof	1 PT Prof	Mult Profs
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19	N=109	N=80	N=91
Nursing	15.7	34.8	4.8	1.8	22.2	25.0	3.6	12.9	24.5	31.6	22.9	8.8	13.2
Medical Doctor	5.7		15.2				14.5	7.0	2.0	5.3	1.8	6.3	9.9
Other Medicine	1.4	1.1	1.0	1.8	3.7	1.9	0.9	1.0	4.1		0.9	1.3	2.2
Law	2.9	2.2	4.8	1.8		1.3	5.5	3.5			2.8	5.0	1.1
Social Work	5.0	6.5	2.9		18.5	5.8	4.5	6.5	2.0		3.7	5.0	6.6
Business	16.8	14.1	17.1	16.1	25.9	14.7	19.1	16.4	22.5	10.5	13.8	18.6	18.7
Liberal Arts	21.8	17.4	15.2	48.2	7.4	26.3	14.5	20.9	26.5	21.1	24.8	23.8	16.5
Public Health	5.4	1.1	8.6	3.6	11.1	3.2	9.1	5.0	2.0	15.8	5.5	3.8	6.6
Other	20.0	17.4	22.9	23.2	11.1	15.4	24.5	20.4	16.3	15.8	16.5	25.0	19.8
No Answer	5.4	5.4	7.6	3.6		6.4	3.6	6.5			7.3	2.5	5.5
TOTAL	100.1	100.0	100.1	100.1	99.9	100.0	99.8	100.1	99.9	100.1	100.0	100.3	100.1

TABLE 15
PRIOR WORK EXPERIENCE OF PERSON IN CHARGE OF PATIENT COMPLAINT FUNCTION

		Job Title				Salary		Highest Level of Education							
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	Below H Sch Grad	H Sch Grad	Train Beynd H Sch	Assoc Dgree	Nursng Diplm	Bachl Dgree	Mastr Dgree	Other Dgree	No Answr
	N=280	N=92	N=105	N=56	N=27	N=156	N=110		N=12	N=57	N=9	N=19	N=72	N=76	N=30	N=5
Health Care Admin	31.8	14.1	61.0	10.7	22.2	17.3	50.9		16.7	19.3	22.2	10.5	20.8	64.5	23.3	20.0
Medical Doctor	6.1		15.2	1.8			14.5			1.8					53.3	
Other Medicine	4.3	4.3	4.8	1.8	7.4	4.5	4.5			5.3		5.3	6.9	2.6		20.0
Nursing	20.4	41.3	9.5	1.8	29.6	30.1	8.2		25.0	8.8	11.1	100.0	16.7	15.8	13.3	20.0
Law	3.2	3.3	4.8	1.8		1.9	5.5				11.1		4.2	2.6	10.0	
Social Work	7.9	13.0	2.9	1.8	22.2	10.9	4.5		8.3	8.8	11.1	5.3	6.9	7.9	10.0	
Personnel	15.4	18.5	12.4	17.9	11.1	16.0	15.5		8.3	24.6	22.2	5.3	13.9	14.5	10.0	20.0
Insurance	3.9	4.3	1.9	3.6	11.1	4.5	2.7			8.8			5.6	2.6		
Office Work	15.4	22.8	8.6	16.1	14.8	19.2	9.1		33.3	36.8	22.2	5.3	13.9	3.9	6.7	
Other	36.4	34.8	21.9	67.9	33.3	42.3	30.9		41.7	49.1	33.3	5.3	47.2	30.3	23.3	20.0
No Answer	3.9	1.1	6.7	5.4		3.2	2.7			3.5			5.6	1.3	6.7	40.0
TOTAL	148.7*	157.5	149.7	130.6	151.7	149.9	149.0		133.3	166.8	133.2	137.0	141.7	146.0	156.6	140.0

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*This total exceeds 100% because some respondents indicated more than one prior work experience.

been the prior work experience of high school graduates and those with some training beyond high school. The "other" category of prior work experience comprises about 36% of total and is truly heterogeneous as revealed by the following write-in work experiences:

- civic leader—member city council
- executive of trade association
- supervisor in private industry
- manufacturer's representative
- chaplain
- Equal Employment Opportunity Office community worker
- clergyman—Salvation Army office
- evacuation pilot
- welfare and recreation administration
- TV announcer
- pharmacist
- Boy Scouts of America—purchasing executive
- housewife
- night watchman.

Table 16 shows that for only 18% of the institutions, speaking any language in addition to English is preferred for the patient complaint function. Another language is preferred more often in those institutions which have a patient complaint job title than in those which have functions with administrative or public relations titles. This suggests that an ethnic factor may have given rise to the designation of this office, and Table 17, which represents the regional distribution of second language preference, shows that respondents from the usual "Spanish-speaking" regions—Region II (New York), Region VI (Texas), Region IX (California)—answered "yes" over one-third of the time. Also Table 16 shows that Federal Government-controlled institutions show almost no preference for an additional language other than English.

A large nonprofit hospital in New York City responded that their Patient Advocate utilizes a "Dial-A-Language" program at the hospital to communicate with non-English-speaking patients or visitors. This program is a data bank of employees throughout the hospital who can speak foreign languages and are easily accessible through the hospital's switchboard.

To summarize a "profile" of formal patient complaint function directors, the data reveals that those with patient complaint titles tend to operate at a lower organizational level than those with administrative titles. They are paid less (under $15,000/year) and have less education. They tend to have nursing work backgrounds, while administrative titles come from health care administration backgrounds. Patient complaint directors are mostly women and administrative directors are mostly men.

Characteristics Of Patient Grievance Offices

The previous section presented the general characteristics of the individual directors of patient complaint offices. This section presents data describing the patient complaint office itself.

About 41% of the institutions report that the patient complaint function has been in existence three years or less as shown in Table 18. Over two-thirds of those with patient complaint titles say that the function has been in existence three years or less compared to only 21% of those with adminstrative titles. Furthermore, 35% of those with administrative titles report that the patient complaint function has been in existence 11 years or more. These findings suggest that, where the patient complaint function is relatively new, it has been positioned at a relatively lower level than in institutions which delegate this function to an administrative title, which, as already shown, tends to be a higher level position in general than the patient complaint function title.

Table 18 also shows, under Type of Control, that Federal Government institutions claim to have a longer history of patient complaint functions than other institutions and that non-Federal Government institutions have a relatively shorter history. Nonprofit and for-profit institutions show a more even distribution by number of years that the patient complaint function has been in operation.

As would be expected, about one-third of those functions in operation one year or less have directors earning salaries under $15,000 per year and about one-third of functions in operation 11 or more years have directors earning over $15,000 per year. Also, Table 18 shows that the older functions are more likely to have more than one professional staff member.

As shown in Table 19, about 96% of the institutions provide 100% funding to patient complaint functions. The only exceptions are attributed to supportive Government funding.

Table 20 shows that about half the institutions have a written job description for the patient complaint function and about half do not. Most important for the relative standing of this function is the fact that 78% of those with patient complaint titles have a written job description for this function and 76% of those with administrative titles do not. About half of the public and/or community relations titles report a written job description and half do not.

In about 76% of the institutions, the person in charge of the patient complaint function is appointed by the chief administrator (Table 21). About 13% are recruited by the personnel office but almost none are elected or selected by physicians, patients or outside community organizations. In some institutions more than one method is used. About 20% report that "other" methods not listed in the table are used and these methods are used mostly by Federal Government-controlled institutions and those providing primarily psychiatric services. Examples of "other" methods are listed below:

- present incumbent set up function as one of his division's duties
- selected by board of trustees
- selected by Director Federal Health Program Service (headquarters)
- medical personnel approved of appointment

TABLE 16
SPEAKING ANY LANGUAGE IN ADDITION TO ENGLISH PREFERRED FOR THE PATIENT COMPLAINT FUNCTION

		Job Title				Salary		Level of Reporting			Type of Control			
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Second	Third	Gov't N-Fed	Gov't Fed	Non-Proft	Proft
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19	N=58	N=36	N=178	N=8
Yes	17.9	29.3	10.5	10.6	22.2	21.8	11.8	16.4	20.4	31.6	22.4	8.3	16.9	50.0
No	76.1	63.0	81.9	85.7	77.8	73.1	82.7	78.6	71.4	57.9	67.2	91.7	77.0	50.0
No Answer	6.1	7.6	7.6	3.6		5.1	5.5	5.0	8.2	10.5	10.3		6.2	
TOTAL	100.1	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	100.1	100.0

TABLE 17
SPEAKING ANY LANGUAGE IN ADDITION TO ENGLISH PREFERRED FOR THE PATIENT COMPLAINT FUNCTION BY REGION

		Region										
	Total	New Eng	NY,NJ	Mid Atl	South	No Centl	So Centl	Mid Centl	Near West	West	No West	Un-Ident
	N=280	N=21	N=37	N=47	N=32	N=60	N=22	N=14	N=8	N=30	N=2	N=7
Yes	17.9	4.8	37.8	10.6	6.3	10.0	36.4	7.1	12.5	36.7	50.0	
No	76.1	90.5	54.1	83.0	87.5	80.0	63.6	92.9	87.5	56.7	50.0	100.0
No Answer	6.1	4.8	8.1	6.4	6.3	10.0				6.7		
TOTAL	100.1	100.1	100.0	100.0	100.1	100.0	100.0	100.0	100.0	100.1	100.0	100.0

TABLE 18
NUMBER OF YEARS PATIENT COMPLAINT FUNCTION HAS BEEN IN OPERATION

						Salary		Level of Reporting			No. of Staff						
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Secnd	Third	1 FT Prof	1 PT Prof	Mult Profs	Gov't N-Fed	Gov't Fed	Non-Proft	Proft
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19	N=109	N=80	N=91	N=58	N=36	N=178	N=8
One year or less	22.5	41.3	8.6	14.3	29.6	32.7	9.1	19.9	20.4	42.1	26.6	22.5	17.6	34.5	19.4	19.7	12.5
Two to three years	18.9	26.1	12.4	23.2	11.1	21.2	16.4	20.9	16.3	15.8	23.9	16.3	15.4	10.3	16.7	23.0	
Four to five years	16.1	17.4	13.3	16.1	22.2	17.3	13.6	13.9	28.6	10.5	13.8	20.0	15.4	19.0	5.6	15.7	50.0
Six to ten years	16.8	8.7	19.0	26.8	14.8	17.3	17.3	16.9	18.4	15.8	17.4	16.3	16.5	12.1	8.3	20.2	12.5
Eleven years or more	19.3	4.3	35.2	14.3	18.5	6.4	35.5	21.9	10.2	15.8	12.8	17.5	28.6	17.2	38.9	15.7	25.0
No answer	6.4	2.2	11.4	5.4	3.7	5.1	8.2	6.5	6.1		5.5	7.5	6.6	6.9	11.1	5.6	
TOTAL	100.0	100.0	99.9	100.1	99.9	100.0	100.1	100.0	100.0	100.0	100.0	100.1	100.1	100.0	100.0	99.9	100.0

TABLE 19
PATIENT COMPLAINT FUNCTION FUNDED 100% BY INSTITUTION

		Job Title				Salary		Level of Reporting			No. of Staff		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Secnd	Third	1 FT Prof	1 PT Prof	Mult Profs
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19	N=109	N=80	N=91
Yes	95.7	94.6	97.1	94.6	96.3	96.2	97.3	96.0	98.0	94.7	95.4	97.5	94.5
No	3.2	4.3	1.0	5.4	3.7	3.2	1.8	3.0		5.3	3.7	1.3	4.4
No Answer	1.1	1.1	1.9			0.6	0.9	1.0	2.0		0.9	1.3	1.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.1	100.0

TABLE 20
WRITTEN JOB DESCRIPTION FOR PATIENT COMPLAINT FUNCTION

		Job Title				Salary		Level of Reporting			Number of Staff		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Secnd	Third	1 FT Prof	1 PT Prof	Mult Profs
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19	N=109	N=80	N=91
Yes	49.3	78.3	22.9	51.8	48.2	63.5	29.1	42.8	67.3	73.7	59.6	33.8	50.6
No	48.6	17.4	76.2	48.2	48.2	34.0	70.0	54.7	30.6	26.3	36.7	66.3	47.3
No Answer	2.1	4.3	1.0		3.7	2.6	0.9	2.5	2.0		3.7		2.2
Total	100.0	100.0	100.1	100.0	100.1	100.1	100.0	100.0	99.9	100.0	100.0	100.1	100.1

TABLE 21
WAY IN WHICH DIRECTOR OF PATIENT COMPLAINT FUNCTION IS SELECTED

		Type of Control				Type of Service		
	Total	Gov't N-Fed	Gov't Fed	Non-Proft	Proft	Gen Med	Psych	Other
	N=280	N=58	N=36	N=178	N=8	N=239	N=25	N=16
Personal Office Recruiting	12.5	15.5	8.3	12.9		13.0	4.0	18.8
Appointment by Chief Administrator	75.7	72.4	55.6	79.8	100.0	77.8	64.0	62.5
Vote of Physicians, Nurses or Other Medical Personnel	1.1	3.4			12.5	0.4	4.0	6.3
Selection or Appointment by an Outside Community Organization	0.7	1.7		0.6		0.4	4.0	
Vote of Patients and Former Patients	1.1	5.2					8.0	6.3
Other Methods	19.6	25.9	38.9	14.6		18.0	36.0	18.8
No Answer	2.1	1.7	2.8	2.2		2.5		
TOTAL	112.8	125.8	105.6	110.1	112.5	112.1	120.0	112.7

- appointment by Veterans Administration Central through their personnel process
- assigned by religious committee
- volunteer function
- chosen by controller
- selected by multidisciplinary screening committee
- appointment by Salvation Army Eastern regional headquarters
- selected in conjunction with law school.

Tables 22, 23, 24, 25 and 26 in this section suggest that those with patient complaint titles are likely to be working alone in this function without additional professional administrative help and most often without clerical help as well. By contrast, those with administrative titles or public relations titles are more likely to be part-time and to have clerical assistance for this and their other job duties.

TABLE 22
NUMBER OF PART-TIME PROFESSIONAL OR ADMINISTRATIVE PERSONS

		Job Title			
	Total	Pat Comp	Admin	PB/CM Relat	Misc
	N=280	N=92	N=105	N=56	N=27
	31.4	16.3	40.0	46.4	18.5
Two	5.4	7.6	4.8	3.6	3.7
Three	3.2		6.7		7.4
Four or More	6.1	2.2	10.5	3.6	7.4
None	53.9	73.9	38.1	46.4	63.0
TOTAL	100.0	100.0	100.1	100.0	100.0

TABLE 23
NUMBER OF FULL-TIME PROFESSIONAL OR ADMINISTRATIVE PERSONS

		Job Title			
	Total	Pat Comp	Admin	PB/CM Relat	Misc
	N=280	N=92	N=105	N=56	N=27
One	41.1	59.8	26.7	39.3	37.0
Two	5.4	10.9	1.9	3.6	3.7
Three	5.0	3.3	6.7	5.4	3.7
Four or More	3.9	3.3	2.9	3.6	11.1
None	44.6	22.8	61.9	48.2	44.4
TOTAL	100.0	100.1	100.1	100.1	99.9

TABLE 24
NUMBER OF FULL-TIME CLERICAL PERSONS

	No. of Staff		
	1 FT Prof	1 PT Prof	Mult Profs
	N=109	N=80	N=91
One	31.2	2.5	24.2
Two	3.7		5.5
Three	0.9		2.2
Four or More	0.9		4.4
None	63.3	97.5	63.7
TOTAL	100.0	100.0	100.0

TABLE 25
NUMBER OF PART-TIME CLERICAL PERSONS

	No. of Staff		
	1 FT Prof	1 PT Prof	Mult Profs
	N=109	N=80	N=91
One	10.1	53.8	16.5
Two		3.8	12.1
Three	1.8	2.5	5.5
Four or More	0.9	1.3	3.3
None	87.2	38.8	62.6
TOTAL	100.0	100.2	100.0

Of the 280 respondents having formal patient complaint functions there are 109 institutions, or 39% of the total, which report only one full-time professional or administrative person in the patient complaint function. As shown in Tables 24 and 25, of these 109, 63% do not have full-time clerical personnel and 87% do not have part-time clerical personnel. There are 80 institutions, or 29% of the total, which report only one part-time professional or administrative person in the patient complaint function. Of these, about 98% have no full-time clerical personnel but 54% have one part-time clerical person and about 39% have none. Finally, there are 91 institutions, or about 39% of the total, which have some combination other than only one full-time or only one part-time professional person. Of these, half report that no professional person is full-time.

With reference to clerical personnel, 64% of these 91 institutions report that there are no full-time clerical personnel and 24% report that there is one. Similarly, with part-time clerical people, about 63% of these 91 institutions report that there are no part-time clerical personnel in the patient complaint and about 17% report one.

The average number of volunteers per day working in this function is shown in Table 26. About 87% of the institutions report no volunteers, and about 6% report an average of one volunteer per day.

Finally, while most institutions report only one patient complaint function, 14% report that there are two or more functions in the institutions which deal with patient complaints as shown in Table 27.

In most institutions, no health care departments are outside the scope of the patient complaint function. Only 9% responded that one or more departments were outside the jurisdiction of the office.

ELEMENTS OF FORMAL PATIENT COMPLAINT SYSTEMS

This section presents survey findings regarding the elements of formal complaint systems.

Complaint Sources

Patients and relatives or friends of patients are most often named as the source of complaints received by the patient complaint function as shown in Table 28. About two-thirds also name the nursing staff and physicians as sources of complaints. About half or less name the institution administrator or his staff, the business or finance office, or the legal department or counsel as the source of complaints.

Table 29 shows which source is reported as the "most frequent" source and, of course, it is the patients themselves. Friends and relatives are named as most frequent by 18% and all other sources named in Table 28 are reported as the "most frequent" source of complaints in Table 29 by a negligible number of these institutions. Some are not even named at all as "most frequent". We note in editing the data for processing that

TABLE 26
AVERAGE NUMBER OF VOLUNTEERS PER DAY

		Type of Control				Type of Service		
	Total	Gov't N-Fed	Gov't Fed	Non-Proft	Proft	Gen Med	Psych	Other
	N=280	N=58	N=36	N=178	N=8	N=239	N=25	N=16
One	6.4	5.2		8.4		7.5		
Two	4.3	1.7	2.3	5.6		4.6		6.3
Three	0.4		2.8			0.4		
Four or More	1.8		2.8	2.2		1.7		6.3
None	87.1	93.1	91.7	83.7	100.0	85.8	100.0	87.5
TOTAL	100.0	100.0	100.1	99.9	100.0	100.0	100.0	100.1

TABLE 27
NUMBER OF PATIENT COMPLAINT FUNCTIONS
IN THE INSTITUTION

		Type of Control			
	Total	Gov't Non-Fed	Gov't Fed	Non-Prft	Prft
	N=280	N=58	N=36	N=178	N=8
Only One Function	86.1	91.4	86.1	84.3	87.5
Two or Three	10.4	5.2	11.1	11.8	12.5
Four or More	3.6	3.4	2.8	3.9	
TOTAL	100.1	100.0	100.0	100.0	100.0

TABLE 28
SOURCES OF PATIENT COMPLAINTS

		Type of Control			
	Total	Gov't N-Fed	Gov't Fed	Non-Prft	Prft
	N=280	N=58	N=36	N=178	N=8
Patients	97.5	91.4	100.0	99.4	87.5
Relatives or Friends of the Patient	96.1	91.4	91.7	98.9	87.5
Nursing Staff	65.7	60.3	75.0	66.3	50.0
Physicians	66.4	58.6	72.2	68.5	50.0
Institution Administrator or His Staff	52.5	48.3	58.3	53.4	37.5
Business or Finance Office	45.4	34.5	30.6	52.8	25.0
Legal Department or Legal Counsel	16.8	20.7	33.3	12.9	
Other	17.1	15.5	38.9	13.5	12.5
No Answer	1.4	3.4		0.6	12.5
TOTAL	458.9	424.1	500.0	466.3	362.5

TABLE 29
MOST FREQUENT SOURCE OF COMPLAINTS
BY JOB TITLE OF PGM

		Job Title			
	Total	Pat Comp	Admin	PB/CM Relat	Misc
	N=280	N=92	N=105	N=56	N=27
Patients	62.9	70.7	53.3	64.3	70.4
Relatives or Friends of the Patient	17.9	16.3	23.8	12.5	11.1
Nursing Staff	1.8	2.2	1.0		7.4
Physicians	0.7		1.0		3.7
Institution Administrator or His Staff					
Business or Finance Office	0.4			1.8	
Legal Department or Legal Counsel					
Other	2.1		2.9	3.6	3.7
No Answer	14.3	10.9	18.1	17.9	3.7
TOTAL	100.1	100.1	100.1	100.1	100.1

those 18% who name friends and relatives as the most frequent source of complaints include a substantial number of institutions for the mentally retarded and those providing primarily psychiatric care. This seems consistent with both the type of patient and type of care provided in these institutions.

Conversations on the telephone or during patient representatiave visits, and letters, are the most common methods of communication of complaints received directly from patients as shown in Table 30. Administrators and public relations persons more frequently report telephone conversations and letters as methods, and those with patient complaint titles more commonly report conversations during patient representative visits. Table 29 corroborates this finding, indicating that 71% of patient complaint titled functions list patients as the most frequent source of complaints, compared with 53% of administrative titles.

Table 30 also indicates that the higher salaried directors (mostly administrative titles) are less likely to visit patient rooms, but more likely to respond to letters. This table and Table 31 indicate that public or community relations titles are more likely to receive complaints via questionnaire.

Table 31 indicates whether respondent institutions use a follow-up questionnaire that asks patients to evaluate the service they received. About 52% of the institutions have a follow-up questionnaire for use with patients at the time of, or after, discharge from the institution's care. Nonprofit institutions are more likely to have a follow-up form than are Government institutions. Use of these questionnaires is more typical of institutions of bed size up to 750 than of larger institutions, and they are least commonly found in psychiatric institutions.

Actions Taken on Complaints

Tables 32, 33 and 34 present data on the procedures which are followed by the patient complaint function. Table 32 indicates that over 80% of the functions settle complaints and act as a go-between between the patient and institution staff while about 70% review incident reports and suggest remedial action. This is much more frequent, however, among those with administrative titles than among those with patient complaint function titles. Reviewing incident reports as a part of the patient complaint function is much more common in some parts of the country than in others as shown in Table 33, which compares regional actions. It is also more common among Government institutions than among nonprofit insitutions. About 37% of the patient complaint functions authorize treatment at no cost to the patient if the complaint has merit. Again this is more common among those with administrative titles and those with higher salaries. This procedure is most often followed by institutions in the West and least often by those in the Mid-Central region and, as indicated in Table 32, it is least characteristic of psychiatric institutions.

About 26% refer complaints with merit to a hearings or advisory board. This procedure is most frequently followed in the South and Near West regions and least often in the Mid-Central and South Central areas. It is most common among Government institutions and increases in frequency with bed size as indicated in Table 34.

Involvement with Legal System

The remaining entries in these three tables refer to procedures followed when legal action is imminent or under way. About 17% will advise patients to seek legal counsel

TABLE 30
METHOD OF COMMUNICATION OF COMPLAINTS RECEIVED FROM PATIENTS

		Job Title				Salary		Type of Control			
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	Gov't N-Fed	Gov't Fed	Non-Proft	Proft
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=58	N=36	N=178	N=8
Conversation on the Telephone with them	61.8	53.3	68.6	67.9	51.9	59.6	66.4	50.0	66.7	64.6	62.5
In Letters	63.2	51.1	72.4	71.4	51.9	58.3	73.6	65.5	80.6	59.0	62.5
Questionnaires Provided By the Institution	48.6	37.0	45.7	71.4	51.9	51.9	44.5	27.6	2.8	65.2	37.5
Conversations During Patient Representative Visits	60.7	87.0	50.5	41.1	51.9	69.2	48.2	51.7	52.8	65.7	50.0
Other	15.0	15.2	19.0	10.7	7.4	10.3	20.9	20.7	30.6	10.7	
No Answer	2.9	1.1	4.8		7.4	2.6	3.6	10.3		0.6	12.5
TOTAL	252.2	244.7	261.0	262.5	222.4	251.9	257.2	225.8	233.5	265.8	225.0

TABLE 31
INSTITUTION HAS FOLLOW-UP QUESTIONNAIRE

		Job Title				Salary		Level of Reporting			No. of Staff			Type of Control			
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Secnd	Third	1 FT Prof	1 PT Prof	Mult Profs	Gov't N-Fed	Gov't Fed	Non-Proft	Proft
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19	N=109	N=80	N=91	N=58	N=36	N=178	N=8
Yes	51.8	51.1	48.6	60.7	48.2	58.3	44.5	50.7	55.1	68.4	52.3	48.8	53.8	24.1	13.9	68.5	50.0
No	43.9	45.7	46.7	33.9	48.2	37.8	50.9	44.3	40.8	31.6	41.3	48.8	42.9	70.7	83.3	28.1	25.0
No Answer	4.3	3.3	4.8	5.4	3.7	3.8	4.5	5.0	4.1		6.4	2.5	3.3	5.2	2.8	3.4	25.0
TOTAL	100.0	100.1	100.1	100.0	100.1	99.9	99.9	100.0	100.0	100.0	100.0	100.1	100.0	100.0	100.0	100.0	100.0

TABLE 32
PROCEDURE WHICH PATIENT COMPLAINT FUNCTION FOLLOWS

		Job Title				Salary		Type of Service		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	Gen Med	Psych	Other
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=239	N=25	N=16
Settles Complaints Itself	81.4	7.61	88.6	71.4	92.6	79.5	85.5	81.6	84.0	75.0
Acts as Go Between Patient/Institution	88.2	93.5	85.7	85.7	85.2	90.4	84.5	88.7	84.0	87.5
Reviews Incidents/ Suggests Action	70.4	57.6	84.8	66.1	66.7	58.3	88.2	68.2	92.0	68.8
Authorizes Treatment At no Cost	37.1	22.8	56.2	26.8	33.3	25.0	52.7	40.2	8.0	37.5
Refers to a Board	26.4	27.2	28.6	19.6	29.6	25.6	28.2	22.6	60.0	31.3
Advises Patient Seek Legal Counsel	16.8	18.5	20.0	3.6	25.9	14.1	20.0	13.0	48.0	25.0
Negotiates with Patient's Lawyers	20.4	13.0	33.3	8.9	18.5	15.4	29.1	18.8	40.0	12.5
Investigates for Insurance Carrier	30.4	16.3	49.5	12.5	40.7	21.2	42.7	33.9	12.0	6.3
Represents Institution in Litigation	21.1	8.7	40.0	8.9	14.8	10.3	35.5	22.6	16.0	6.3
Represents Patient in Litigation	3.9	4.3	4.8		7.4	3.8	2.7	2.9	12.0	6.3
Acts as Wtiness for Institution	36.4	19.6	60.0	21.4	33.3	21.8	57.3	36.8	40.0	25.0
Acts as Witness for Patient	17.9	16.3	21.9	5.4	33.3	14.1	22.7	15.1	44.0	18.8
No Answer	4.3	3.3	3.8	7.1	3.7	3.8	4.5	4.2	4.0	6.3
TOTAL	454.7	377.2	577.2	337.4	485.0	383.3	553.6	448.6	544.0	406.6

TABLE 33
PROCEDURES WHICH PATIENT COMPLAINT FUNCTION FOLLOWS BY REGION

		Region										
	Total	New Eng	NY,NJ	Mid Atl	South	No Centl	So Centl	Mid Centl	Near West	West	No West	Un-Ident
	N=280	N=21	N=37	N=47	N=32	N=60	N=22	N=14	N=8	N=30	N=2	N=7
Settles Complaints Itself	81.4	71.4	83.8	87.2	87.5	75.0	90.9	78.6	62.5	86.7	50.0	71.4
Acts as Go Between Patient/Institution	88.2	90.5	91.9	95.7	81.3	86.7	95.5	92.9	75.0	83.3	50.0	71.4
Reviews Incidents/ Suggests Action	70.4	95.2	56.8	59.6	90.6	63.3	81.8	57.1	87.5	80.0		57.2
Authorizes Treatment At no Cost	37.1	47.6	35.1	27.7	46.9	35.0	36.4	14.3	25.0	60.0		28.6
Refers to a Board	26.4	38.1	21.6	17.0	56.3	16.7	36.4	14.3	50.0	23.3		14.3
Advises Patient Seek Legal Counsel	16.8	33.3	8.1	10.6	31.3	8.3	31.8	7.1	37.5	20.0		
Negotiates with Patient's Lawyers	20.4	47.6	13.5	17.0	25.0	15.0	18.2	14.3	12.5	30.0	50.0	
Investigates for Insurance Carrier	30.4	33.3	29.7	27.7	25.0	33.3	36.4		25.0	46.7	50.0	14.3
Represents Institution In Litigation	21.1	23.8	21.6	14.9	28.1	21.7	18.2	14.3	25.0	30.0		
Represents Patient In Litigation	3.9	19.1	2.7	4.3	6.3	1.7				3.3		
Acts as Witness for Institution	36.4	47.6	29.7	25.5	59.4	26.7	45.5	21.4	50.0	53.3		14.3
Acts as Witness for Patient	17.9	28.6	10.8	14.9	37.5	15.0	22.7		37.5	13.3		
No Answer	4.3	4.8	5.4		3.1	5.0		7.1	12.5		50.0	28.6
TOTAL	454.7	580.9	410.7	402.1	578.3	403.4	513.8	321.4	500.0	529.9	250.0	300.1

TABLE 34
PROCEDURES WHICH PATIENT COMPLAINT FUNCTIONS FOLLOW

		Type of Control				No. of Beds					
	Total	Gov't N-Fed	Gov't Fed	Non-Proft	Proft	200 -299	300 -399	400 -499	500 -749	750+	Under 200/NA
	N=280	N=58	N=36	N=178	N=8	N=71	N=57	N=52	N=46	N=41	N=13
Settles Complaints Itself	81.4	84.5	88.9	78.7	87.5	81.7	80.7	84.6	78.3	82.9	76.9
Acts as Go Between Patient/Institution	88.2	89.7	88.9	87.1	100.0	88.7	89.5	86.5	93.5	87.8	69.2
Reviews Incidents/ Suggests Action	70.4	81.0	83.3	63.5	87.5	67.6	61.4	78.8	63.0	87.8	61.5
Authorizes Treatment At no Cost	37.1	27.6	16.7	42.7	75.0	39.4	33.3	38.5	39.1	24.4	69.2
Refers to a Board	26.4	48.3	36.1	18.0	12.5	16.9	21.1	28.8	30.4	39.0	38.5
Advises Patient Seek Legal Counsel	16.8	36.2	30.6	7.9	12.5	11.3	10.5	23.1	8.7	39.0	7.7
Negotiates with Patient's Lawyers	20.4	27.6	16.7	18.0	37.5	18.3	19.3	17.3	19.6	31.7	15.4
Investigates for Insurance Carrier	30.4	25.9	5.6	35.4	62.5	38.0	26.3	32.7	28.3	22.0	30.8
Represents Institution In Litigation	21.1	20.7	16.7	21.3	37.5	19.7	24.6	25.0	13.0	19.5	30.8
Represents Patient In Litigation	3.9	10.3	2.8	1.7	12.5	2.8	1.8	3.8	4.3	7.3	7.7
Acts as Witness for Institution	36.4	37.9	38.9	34.8	50.0	36.6	36.8	46.2	21.7	34.1	53.9
Acts as Witness for Patient	17.9	32.8	16.7	12.4	37.5	15.5	15.8	17.3	10.9	26.8	38.5
No Answer	4.3	3.4	2.8	5.1		2.8	5.3	3.8	2.2	4.9	15.4
TOTAL	454.7	525.9	444.7	426.6	612.5	439.3	426.4	486.4	413.0	507.2	515.5

if the complaint is serious and about 20% will negotiate with patient lawyers to resolve complaints. By contrast, about 30% will investigate complaints for the institution's insurance carrier. About 21%, mostly those with administrative titles, will represent the institution if the complaint goes to arbitration or litigation, but 36% will act as a witness for the institution in court suits if requested or subpoenaed. By contrast, only about 4% will represent the patient in arbitration or litigation, although about 18% will act as a witness for the patient in court suits if requested or subpoenaed.

In general, patient complaint functions *do not* get involved with legal affairs of patients. Many respondents indicated that such a situation had never come up and a few stated, "Not likely!" or equivalent exclamations. In short, respondents either divorced themselves from any legal involvement or indicated they would help if asked. Examples of cases where the complaint function does assist patients to obtain legal assistance to help them with their complaints against institutions, or their staffs, are listed as follows:

- "If the patient feels he was dealt with unjustly and wishes to pursue legal action, he is helped to secure counsel, or if the patient's financial situation is such, a referral is made to the Legal Aid Society."
(Nonprofit hospital, 400-499 beds, California)
- "If the patient is not satisfied with an answer to his complaint, he is advised to speak to the hospital's attorney or the President of the Board of Trustees."
(Nonprofit hospital, 300-399 beds, Pennsylvania)
- "There is a legal intern program at the local university which will advise patients."
(Nonprofit hospital, 300-399 beds, Kentucky)
- "A Legal Aid Society lawyer is now working with the hospital in collection of a bill that was denied by an insurance company. If we don't collect, it will no doubt be a charity write-off."
(Nonprofit hospital, 300-399 beds, Pennsylvania)
- "Yes, although rarely (twice in the past four years). Usually, a patient determined to bring action against either the hospital or the staff will have an attorney. However, in the two instances referred to, the patient was referred to the Legal Aid Society."
(Nonprofit hospital, 500-749 beds, California)

Most respondents answered a flat "No" to this question and one blamed the legal system for this response by saying, "No! If a complaint appears to be one which may involve a lawsuit against the institution, information on how copies of records can be obtained is provided, but the contingency system makes any advice on obtaining legal assistance unnecessary."

In the case of Government-operated hospitals, the following statement best answers the question of legal assistance:

- "A 'yes or no' answer is not possible. No officer of the U.S. Government is authorized to represent a party with respect to a claim against the Government. However, patients needing legal assistance are referred to Air Force Judge Advocates assigned on base. They provide such assistance as is authorized by Air Force Regulation 110-4. If the patient desires to pursue a claim against the Government for the value of monies or property lost by the Medical Center staff, the assistance in completing the claim filing requirements can be provided, as can an investigation and, if appropriate, reimbursement for the loss. Personal injury claims, however, while they can be accepted by the Judge Advocates, are beyond the scope of assistance insofar as advising on the claim is concerned. The patient would have to consult private counsel for such assistance."
(Air Force hospital, 300-399 beds, California)

Types of Patient Complaints Dealt with by the Complaint Function

Tables 35 and 36 show the types of complaints with which patient complaint functions can deal. These tables show that most of the listed complaints are dealt with by most institutions with notable exceptions such as: only about 60% will deal with insurance or third-party payments, only 53% with physical injuries due to alleged physician negligence, and 59% with medication misdosages.

It is clear from the data in Table 35 that the complaints pertaining to physical injury are much more likely to be dealt with by the patient complaint function when the person in charge has an administrative title than when he has a patient complaint title. The implication again is that those with patient complaint titles are relatively unlikely to deal with the more serious complaints having potential for malpractice litigation.

Table 36 indicates the difference in types of complaints lodged in general medical and psychiatric hospitals. Eighty-four percent of the psychiatric hospitals address complaints of injury due to physician or nurse negligence while only 49% of complaint functions in general medical institutions will handle injury complaints lodged against physicians. On the other hand, complaints about billings and insurance payments are significantly less prevalent in psychiatric hospitals. Also, Table 36 shows that Government-controlled hospitals are more likely to handle complaints regarding medication misdosages, alleged physician negligence, and services of physicians than are nonprofit institutions.

TABLE 35
TYPES OF COMPLAINTS WITH WHICH THE PATIENT COMPLAINT FUNCTION CAN DEAL

		Job Titles				Salary		Level of Reporting		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	First	Secnd	Third
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=201	N=49	N=19
Attitudes of Nurses	93.9	93.5	93.3	98.2	88.9	94.2	93.6	94.0	93.9	94.7
Services of Nurses	93.9	93.5	92.4	98.2	92.6	94.9	93.6	95.0	91.8	89.5
Attitudes of Physicians	77.5	73.9	86.7	64.3	81.5	76.3	80.0	78.6	71.4	79.0
Services of Physicians	72.9	68.5	81.9	60.7	77.8	69.9	78.2	72.6	73.5	68.4
Hospital Bills	81.4	81.5	79.0	89.3	74.1	84.0	77.3	82.6	73.5	94.7
Insurance or Third Party Payments	59.6	51.1	66.7	57.1	66.7	54.5	67.3	63.2	44.9	68.4
Physical Injuries Due to Alleged Physician Negligence	53.2	33.7	77.1	37.5	59.3	41.0	70.0	57.2	34.7	52.6
Physical Injuries Due to Alleged Nurse Negligence	68.6	53.3	87.6	55.4	74.1	59.0	82.7	72.1	55.1	63.2
Housekeeping or Maintenance	93.2	92.4	95.2	92.9	88.9	94.2	92.7	92.5	95.9	94.7
Physical Injuries Due to Falls	70.7	57.6	87.6	55.4	81.5	60.9	84.5	71.6	61.2	84.2
Dietary Services	93.6	92.4	94.3	96.4	88.9	94.9	92.7	94.5	89.8	94.7
Emergency Room Delays	76.8	69.6	82.9	87.5	55.6	75.6	79.1	78.1	73.5	84.2
Medication Misdosages	58.9	38.0	85.7	44.6	55.6	44.9	78.2	63.2	42.9	52.6
Admitting Procedures	87.9	83.7	91.4	89.3	85.2	85.9	91.8	89.1	83.7	94.7
Lost Property	92.5	90.2	94.3	91.1	96.3	90.4	96.4	93.0	91.8	94.7
Outpatient Procedures	74.3	58.7	85.7	80.4	70.4	67.9	84.5	76.1	71.4	68.4
Minor Patient Inconveniences	83.2	88.0	79.0	85.7	77.8	85.3	79.1	80.6	91.8	84.2
No Answer	2.1	3.3	1.9	1.8		1.3	2.7	2.5		
TOTAL	1334.2	1222.9	1462.7	1285.8	1315.2	1275.1	1424.4	1356.5	1240.8	1362.9

TABLE 36
TYPES OF COMPLAINTS WITH WHICH THE PATIENT COMPLAINT FUNCTION CAN DEAL BY TYPE OF HOSPITAL

		Type of Control				Type of Service		
	Total	Gov't N-Fed	Gov't Fed	Non-Proft	Proft	Gen Med	Psych	Other
	N=280	N-58	N=36	N=178	N=8	N=239	N=25	N=16
Attitudes of Nurses	93.9	91.4	88.9	96.1	87.5	95.4	84.0	87.5
Services of Nurses	93.9	93.1	86.1	96.1	87.5	95.0	88.0	87.5
Attitudes of Physicians	77.5	82.8	88.9	74.2	62.5	76.6	84.0	81.3
Services of Physicians	72.9	84.5	86.1	66.9	62.5	71.1	84.0	81.3
Hospital Bills	81.4	62.1	55.6	92.7	87.5	87.4	36.0	62.5
Insurance or Third Party Payments	59.6	50.0	47.2	64.6	75.0	61.9	36.0	62.5
Physical Injuries Due to Alleged Physician Negligence	53.2	74.1	72.2	43.3	37.5	49.0	84.0	68.8
Physical Injuries Due to Alleged Nurse Negligence	68.6	79.3	72.2	65.7	37.5	66.5	84.0	75.0
Housekeeping or Maintenance	93.2	87.9	88.9	96.1	87.5	94.1	88.0	87.5
Physical Injuries Due to Falls	70.7	70.7	77.8	69.7	62.5	70.7	64.0	81.3
Dietary Services	93.6	91.4	94.4	95.5	62.5	94.6	92.0	81.3
Emergency Room Delays	76.8	56.9	80.6	83.7	50.0	84.9	32.0	25.0
Medication Misdosages	58.9	60.3	83.3	54.5	37.5	58.2	64.0	62.5
Admitting Procedures	87.9	84.5	91.7	88.8	75.0	89.5	80.0	75.0
Lost Property	92.5	93.1	94.4	92.1	87.5	92.9	92.0	87.5
Outpatient Procedures	74.3	67.2	88.9	74.2	62.5	78.2	64.0	31.3
Minor Patient Inconveniences	83.2	75.9	77.8	88.2	50.0	84.9	76.0	68.8
No Answer	2.1	3.4	2.8	1.1	12.5	1.7	4.0	6.3
TOTAL	1334.2	1308.6	1377.8	1343.5	1125.0	1352.6	1236.0	1212.9

Each institution was asked to indicate which three of the types of complaints were most frequent in their experience. Table 37 indicates that attitudes and services of nurses, hospital bills, dietary services, emergency room delays, lost property, and minor patient inconveniences are all reported as "most frequent" by 20% or more of the institutions responding. No one type of complaint is reported as one of the three most frequent types more than 31% of the time. Physical injuries and medication misdosages are among the least often named as "most frequent" types of complaints.

Administrative and public/community relations titles set a higher priority on hospital bills than do patient complaint titles. However, the latter ranks attitudes and services of nurses higher than do those with administrative titles. These findings are expected since patient complaint titled functions work more closely with nurses on the floor, while administrators are more sensitive to financial matters.

TABLE 37
MOST FREQUENT TYPE OF COMPLAINTS RECEIVED BY THE PATIENT COMPLAINT FUNCTION

		Job Title				No. of Beds					
	Total	Pat Comp	Admin	OB/CM Relat	Misc	200 -299	300 -399	400 -499	500 -749	750+	Under 200/NA
	N=280	N=92	N=105	N=56	N=27	N=71	N=57	N=52	N=46	N=41	N=13
Attitudes of Nurses	25.7	38.0	14.3	28.6	22.2	25.4	14.0	25.0	43.5	26.8	15.4
Services of Nurses	26.1	33.7	18.1	28.6	25.9	25.4	26.3	17.3	32.6	31.7	23.1
Attitudes of Physicians	12.9	14.1	18.1	5.4	3.7	5.6	7.0	13.5	8.7	34.1	23.1
Services of Physicians	6.1	5.4	8.6	1.8	7.4	4.2	5.3	9.6	6.5	2.4	15.4
Hospital Bills	28.9	14.1	37.1	46.4	11.1	31.0	36.8	30.8	30.4	14.6	15.4
Insurance or Third Party Payments	6.8	6.5	7.6	3.6	11.1	5.6	8.8	7.7	4.3	2.4	23.1
Physical Injuries Due to Alleged Physician Negligence	0.4		1.0							2.4	
Physical Injuries Due to Alleged Nurse Negligence	1.4		3.8				3.5			4.9	
Housekeeping or Maintenance	18.2	20.7	13.3	23.2	18.5	18.3	21.1	13.5	19.6	12.2	38.5
Physical Injuries Due to Falls	7.5	1.1	15.2	5.4	3.7	9.9	8.8	3.8	2.2	9.8	15.4
Dietary Services	31.1	40.2	18.1	37.5	37.0	31.0	43.9	34.6	30.4	17.1	7.7
Emergency Room Delays	21.1	15.2	23.8	25.0	22.2	25.4	28.1	21.2	21.7	9.8	
Medication Misdosages	1.4	2.2	1.9			1.4		1.9		4.9	
Admitting Procedures	11.4	3.3	17.1	14.3	11.1	8.5	8.8	13.5	17.4	9.8	15.4
Lost Property	21.4	15.2	24.8	16.1	40.7	23.9	14.0	28.8	19.6	17.1	30.8
Outpatient Procedures	11.8	9.8	17.1	3.6	14.8	8.5	12.3	11.5	10.9	19.5	7.7
Minor Patient Inconveniences	26.8	27.2	21.0	26.8	48.2	28.2	21.1	30.8	21.7	34.1	23.1
No Answer	10.7	14.1	9.5	8.9	7.4	14.1	8.8	9.6	8.7	12.2	7.7
TOTAL	269.7	260.8	270.4	275.2	285.0	266.4	268.6	273.1	278.2	265.8	261.8

Taken together, Tables 35, 36 and 37 suggest that physical injuries to patients and medication misdosages are least likely to occupy the time and attention of patient complaint functions, presumably, in part, because they are the least frequent type of complaint. When complaints in these areas arise, they are more likely to be handled by those with administrative titles than by those with patient complaint titles. This merely confirms what is common management practice—the more serious the issue, the more likely it is to require executive level decision makers to resolve it.

Tables 38 and 39 deal with the limits on the financial authority of the patient complaint function. Table 38 indicates which of four types of patient complaint injuries or incidents plus "other" payments can be waived by the patient complaint function. For the most part, the patient complaint function cannot waive payment for any of these types of injuries or incidents. About 29% report they can waive payment for hospital bills due to falls but only about 19% can waive payment for medication misdosages and about 14% for malpractice caused bills. About 7% report they can waive payment for other types of injuries or incidents.

In only 13% of the institutions can the patient complaint function waive payment for remedial treatment related to an incident without prior approval of other executives in the institution. Most of these 13% are institutions with administrative titles (and those making higher salaries) in charge of patient complaints as shown in Table 39. Only 2 percent report no financial limits on this authority and 3 percent report $100 or less and 1 percent $100 or more. One respondent (a large nonprofit hospital in New York City) cited the following example of a case for payment waiver:

> "Personnel on the administrative staff can waive payment for medical services rendered as a result of a fall in the hospital, if the person who falls signs a statement of release. These personnel are the Executive Vice President, the Administrator, the Associate Director, the Assistant Director and the Administrative Assistant."

The majority of institutions did not answer this latter question because those who said "No" or gave no answer to the prior question in Table 38 were not expected to answer it. Part of the reason for the high percent of "no answers"

TABLE 38
TYPES OF INJURIES OR ACCIDENTS IN WHICH PAYMENT CAN BE WAIVED BY THE PATIENT COMPLAINT FUNCTION

		Job Title				Type of Service		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Gen Med	Psych	Other
	N=280	N=92	N=105	N=56	N=27	N=239	N=25	N=16
FALLS								
Payment can be waived	29.3	17.4	37.1	33.9	29.6	32.6	4.0	18.8
Payment cannot be waived	70.7	82.6	62.9	66.1	70.4	67.4	96.0	81.3
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.1
MEDICATION								
Payment can be waived	18.9	12.0	26.7	16.1	18.5	21.3		12.5
Payment cannot be waived	81.1	88.0	73.3	83.9	81.5	78.7	100.0	87.5
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
HOSPITAL BILLS								
Payment can be waived	29.3	16.3	38.1	35.7	25.9	31.8	4.0	31.3
Payment cannot be waived	70.7	83.7	61.9	64.3	74.1	68.2	96.0	68.8
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.1
MALPRACTICE								
Payment can be waived	13.9	7.6	19.0	16.1	11.1	15.1		18.8
Payment cannot be waived	86.1	92.4	81.0	83.9	88.9	84.9	100.0	81.3
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.1
OTHER								
Payment can be waived	6.8	8.7	4.8	7.1	7.4	8.0		
Payment cannot be waived	93.2	91.3	95.2	92.9	92.6	92.1	100.0	100.0
TOTAL	100.0	100.0	100.0	100.0	100.0	100.1	100.0	100.0

TABLE 39
PATIENT COMPLAINT FUNCTION CAN WAIVE PAYMENT FOR REMEDIAL TREATMENT RELATED TO AN INCIDENT WITHOUT APPROVAL OF THE OTHER EXECUTIVES IN THE INSTITUTION

		Job Title				Salary		Type of Service		
	Total	Pat Comp	Admin	PB/CM Relat	Misc	Under 15000	15000 & Ovr	Gen Med	Psych	Other
	N=280	N=92	N=105	N=56	N=27	N=156	N=110	N=239	N=25	N=16
CAN WAIVE PAYMENT										
Yes	13.2	1.1	24.8	14.3	7.4	5.8	22.7	14.6	4.0	6.3
No	67.9	79.3	52.4	71.4	81.5	79.5	53.6	69.9	56.0	56.3
No Answer	18.9	19.6	22.9	14.3	11.1	14.7	23.6	15.5	40.0	37.5
TOTAL	100.0	100.0	100.1	100.0	100.0	100.0	99.9	100.0	100.0	100.1
FINANCIAL LIMITS										
None	2.1		4.8	1.8		0.6	4.5	2.1		6.3
$100 or less	2.9	1.1	1.9	7.1	3.7	3.2	2.7	3.3		
Over $100	1.1		1.9	1.8			2.7	1.3		
No Answer	93.9	98.9	91.4	89.3	96.3	96.2	90.0	93.3	100.0	93.8
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	100.0	100.1

is that many of the Government-controlled institutions do not require payment from patients for any of the treatment they give, whether remedial or not. This is particularly the case with *Federal* Government institutions. Also, many respondents felt that waiver of payment was an admission of wrongdoing and could be used as evidence against the institution in any subsequent suits. One respondent expressed this feeling by saying, "It is my feeling that waiving payment is an admission of guilt (liability). A fall may not necessarily result from an error in judgment, and medication errors do not usually lead to patient complaints."

On the other hand, an institution visisted cited that any patients with large bills will provoke suits just to try for a reduction of payment, and the probability of suit is high if any incident reports are attached to a large-bill case. Therefore, this institution reviews all large bills and will waive some payment just to reduce the chance of suit being filed.

PROCESSES FOR DEALING WITH ALL TYPES OF PATIENT COMPLAINTS

In both the mail survey and the on-site case studies, respondents were asked to describe their procedures for handling patient complaints. Most formal patient complaint functions follow a basic task pattern when dealing with patient complaints, which is:

1) To receive complaints through reports, room visits, telephone calls, or second-party referrals
2) To hear the patient's side of the story
3) To investigate the complaint with all parties concerned
4) To make corrections and resolve problems
5) To follow up to see that the problem has been remedied and that patients are satisfied.

If complaints cannot be resolved, they are usually passed on to department heads or to hospital administration for resolution, with the patient complaint function playing a minor role in subsequent resolution activities. If the complaint alleges malpractice, top administration, legal counsel and the insurance carrier handle such complaints. Actual descriptions of the usual procedures used by respondents to resolve patient complaints are presented as follows:

- 1. Hear the patient's side of the story.
  2. Communicate with all other involved individuals.
  3. Review the medical record, if appropriate.
  4. Evaluate degree of hospital liability.

  An administrator handling a patient complaint would have nearly unlimited authority whereas a Patient Relations Hostess would be quite more limited in her authority and would deal primarily with 'contact' complaints which she could resolve. All others she would refer to an administrator for resolution.

  (Nonprofit, 500-749 beds, California)
- "1) Visit patient—investigate complaint (patient's standpoint).
  2) Investigate complaint re department involved.
  3) Make corrections when possible (apologize, correct function, etc.).

4) Continue to visit patient on daily basis to make sure patient's complaint has been correctd.
5) If complaint cannot be handled by patient coordinator, then it is turned over to Administration, e.g., in case of patient complaining of malpractice and wanting to sue hospital, etc."

(Nonprofit, 200-299 beds, Pennsylvania)

- 1) Attempt to discover what the problem is—which means providing a sounding board for family, friends, and/or patient.
  2) Attempt to ascertain what action, if any would satisfy the individual voicing the complaint—without specifically asking.
  3) Investigate the components of the complaint with the appropriate members of the hospital staff—and attempt to determine the validity of the complaint.
  4) If the hospital is at fault—do everything possible to correct the problem—assure patient that corrective action has been taken and express appreciation for the matter being brought to our attention. If legal involvement appears to be likely—consult with hospital insurance carrier and make sure that no liability is admitted.

  A patient complaint (that is not satisfied at the nursing unit or service department level) always involves highest level of management. Although the point for patient complaints is with an Associate Administrator, many other people play vital roles. . . . Resolving patient complaints requires a team approach at our institution and someone at thc head of the team to assure that fast objective action is taken on cach complaint.

  (Nonprofit, 400-499 beds, Texas)

- The patient makes his complaint to the nurse who reports it to the head nurse. Hopefully it can be resolved on the spot to the patient's satisfaction. If the complaint cannot be resolved, it is reported to the Director of Nursing Service who will attempt to resolve the problem. If this fails, the Assistant Administrator will then attempt to handle the patient with the complaint.

  Many times a patient just wants someone in authority to hear his complaint. He does not want to hear that "hospital employees would not do such a thing"

  (Church-operated, 300-399 beds, Claifornia)

- "1) Investigation—personal contact with patient or patient's family, hospital staff and physician.
  2) Written report including evaluation of situation and recommendations.
  3) Personal conferences with department heads involved until patient satisfaction is reached *or*
  4) Referral to administrator, then legal department, labor relations department, Patient Care Committee, Medical Board, etc., as needed.
  5) Act as patient's representative before various levels of authority involved in the problem, within the hospital.
  6) Report final disposition of the problem to the patient by personal visit, if possible, or by letter."

  (Unidentified)

- "The person responsible for the patient complaint function makes no immediate judgment, but indicates to the complaining person that she will investigate the complaint and get in touch with him by phone or letter. She then thoroughly investigates the circumstances surrounding the incident or situation, implements a remedy if possible, or may simply apologize to the complaining person if only that is possible. The Director is consulted regarding possible litigations or problems involving sums of money larger than outpatient charges."

  (Nonprofit, 200-299 beds, New Jersey)

Processes Used in Government-Operated Institutions

As shown in Table 1, one-third of respondents indicating the presence of a formal patient complaint function (A respondents) are Government operated. Of these, most were Armed Forces, Veterans Administration or state hospitals (usually mental health).

As would be expected, the processes used by these institutions reflect the systematic, "by-the-book" approaches taken in the Government (particularly the Armed Forces) and appear more secure about malpractice problems, since the Government is difficult to sue. The following verbatim responses represent the Government-controlled respondents (note variety of patient complaint function titles).

- "A. Upon receipt, Xerox copy made of correspondence.
  B. Description of correspondence entered in log—Source (i.e., Congressional, Service Dept., ctc.); Paticnt's name; address; date received; inpatient or outpatient?; complimentary or complaint correspondence; brief des-

cription of complaint; forward to Service/Division (i.e., Med. Administration, Nursing, Surgical, etc.); date forwarded; date reply received for signature of Director; remarks.

C. Reply is forwarded to Director for signature through Chief of Staff and Assistant Director.

D. Normal reply time for complaint correspondence limited to 48 hours from receipt (Expeditious Special Handling).

In infrequent instances, the Director or Chief of Staff may prepare a reply personally if situation dictates."

(Veterans' Administration, 400-499 beds, Oklahoma)

- "a) The patient complaints are received by *PAL (Patient Affairs Liaison)* and all possible information which is relevant to the problem is gathered by the PAL officer. PAL operates as a staff officer to the Hospital Commander; therefore, all divisions and services of the hospital cooperate in assisting the PAL. Every attempt is made to resolve the patient's problem at the lowest organizational level but when necessary the Hospital Commander is informed regarding the patient's problem and he provides solution. In all cases the patient is informed regarding the final outcome.

  b) PAL authority is that of a staff agency which functions at the top level within the Medical activity."

  (Army, 400-499 beds, South Carolina)

- "When complaints are received the matter is referred to the duty *Administrative Watch Officer.* Pertinent information is recorded on a complaint documentation form, as the complainer is interviewed. Complaints of an administrative nature are handled at this level, if possible. If a solution cannot be reached, the matter is referred to the Administrative Officer.

  Complaints involving patient care or medical practices are referred to physician department heads. If unable to resolve the problem at this level the problem is referred to the Executive Officer or Commanding Officer."

  (Navy, 200-299 beds, Florida)

- "We attempt to resolve all patient complaints at the lowest level of management. If the patient complains to the parties involved and they cannot satisfy the patient he may file a complaint with the *Special Inquiries Office.* All patients are interviewed unless they file a written complaint. We investigate all complaints and gather as much detailed information as is possible concerning the points of view of the parties involved. The facts are then reviewed by the Hospital Commander and/or the Chief of Professional Services, and action is taken accordingly. The patient is advised of our findings and action taken."

  (Army, 750-999 beds, Georgia)

- "After initial investigation most complaints are based on a misunderstanding and are easily rectified by conveying the correct information to the complaining party or to hospital staff as appropriate. The *Health Benefits Counselor* has easy access to personnel on all levels of the organizational hierarchy. Rectifying action or changes in procedures can be recommended to the appropriate official. Disagreements are referred to a higher level.

  In cases which cannot be satisfactorily settled because of a patient's disagreement with substantial hospital policies or because of some other operating limitation, the hospital's position is presented to the complaining party."

  (Navy, 300-399 beds, Rhode Island)

An Armed Forces hospital visited has five processes for handling patient complaints in addition to the normal military chain of command. These processes are:

a "Sound Off" program. This confidential program provides answers to comments, complaints and suggestions.

Patient Questionnaire. A questionnaire is given to patients upon their discharge, requesting comments on all facets of health care provided.

Congressional letters. The Commanding Officer receives Congressional inquiries following complaints by their constituents.

Wives' Ombudsmen. This program has an enlisted men's wives' ombudsman and an officers' wives' ombudsman who have direct access to the Commanding Officer.

Staff Judge Advocate. This office is in the hospital and handles complaints that cannot be resolved at the department level.

Other Processes for Dealing with Patient Complaints in Institutions

Other processes for dealing with patient complaints involve committee or council participation and some approaches unique to single institutions. Examples of these processes are presented as follows:

- During routine rounds in the institution, the employees in charge of the buildings and residents report complaints to the Chairman, or to the members of the *Human Rights Advisory Committee* . . .

(State-operated, Rehabilitation Center, New York)

- . . . .If the complaint concerns a physician or a trustee, the report is given to the Director and handled by him, or is taken by him to the *Executive Committee of the Board of Trustees* or the *Executive Committee of the Medical Staff.*

(Nonprofit, 300-399 beds, Rhode Island)

- If a satisfactory solution to a complaint cannot be worked out with administration, the complaint is brought before the *Administrative Council* (10 people) which meets twice a week. . . .

(Church-operated, 300-399 beds, Colorado)

- We have a *Patient Council* (four employees selected by patients and two patient members per floor) which meets the first and third Thursdays of each month. (Patients average 90 to 100 days per stay.)

(State-controlled, Respiratory Diseases, Maryland)

- The Executive Director may become involved if suggested resolution is not acceptable. If his resolution is not acceptable, the matter may be referred to a *Grievance Committee of the Board of Directors* and then to the full Board.

(Nonprofit, ambulatory hospital, Rhode Island)

- Patient complaints may also be taken to the *Patient Care Committee*, a group whose aim is to ensure the best total care of the patient, including the formulation and implementation of policies.

(Church-operated, 300-399 beds, Washington, D.C.)

- "At the direction of the Community Relations Director, some patients are invited back to the hospital for a *luncheon meeting* to discuss complaints with staff first hand."

(Nonprofit, 300-399 beds, Illinois)

Additional Avenues for Resolving Patient Complaints

No hospitals surveyed indicated that all complaints were handled by *one* office within the institution, but instead, complaint resolution was a task of many offices, usually those closest to the subject of the complaint, and patients could take their complaints to a number of other groups for resolution.

Non-Government, nonprofit institutions for the most part cited other internal staff functions as avenues for complaint resolution with statements such as:

- The most effective way [to handle complaints] is still the referral through workers-supervisors channels. Any patient has direct access to the top executive officer, the Administrator.

(Nonprofit, 200-299 beds, Georgia)

- The patient may complain to the nurse or to the supervisor of the department involved in the complaint, or to his or her doctor or directly to the Executive Administrator's office.

(Nonprofit, 200-299 beds, New York)

However, more public institutions tend to suggest organizations outside the operational hierarchy as demonstrated by the following actual responses describing additional avenues for resolving patient complaints.

- There are many avenues . . . including the community advisory board, the Patient Councils, the President's Council, and the newspaper, which is uncensored. . . .

(Public Benefit Corporation, 750-999 beds, New York)

- The patient has the privilege of personally visiting with either the hospital Chief of Staff, the Assistant Hospital Director or the Hospital Director. In addition, the veterans' service organizations have representatives at the hospital and . . . many complaints are received directly from members of Congress from our Congressional liaison service.

(Veterans' Administration, 1,000+ beds, Missouri)

- All elements of the hospital are geared to handle patient complaints. Most complaints made by patients to Congressmen are handled by the office of the Adjutant in Hospital Headquarters. Military patients are assigned to the Medical Holding Company and register complaints with the Commanding Officer of that unit. All patients have access to the Hospital Chaplains, Judge Advocate, Provost Marshal, Social Work Service, Army Community Service, and many other offices capable of responding to complaints and requests for assistance.

(Army, 750-999 beds, Colorado)

- Yes, patients may complain directly to the hospital through the Ombudsman or the hospital command line. Additionally, the various local Navy Commands maintain an "Action Line" which requires written report between the Commanding Officers of corrective action taken or

explanation of services. Also beneficiaries of the Military Medical System may correspond directly with Congressmen or other elected officials, and government agencies to institute an investigation.
(Navy, 300-399 beds, South Carolina)

- A direct daily follow-through of patients' problems is the usual procedure of the *Patient Care Coordination Team.* If this is neither productive nor possible because it is out of our realm of problem solving, the matter is referred. For instance, over the first six-month period of 1972, there were 2,471 referrals made to the Offices of the American Red Cross, Marine Liaison, Patient Affairs, Legal, Disbursing, Veterans Administration, Navy Relief, *Champus*, local military bases and the Personnel Office.
(Navy, 1,000+ beds, California)

Processes Used to Deal with Malpractice Claims

In almost all cases, respondents with formal complaint functions indicated that potential and actual malpractice events or claims are the responsibility of top administration, legal counsel (often on insurance carrier's staff) and the insurance carrier. Also, a few indicated referral of malpractice problems (or suits) to medical societies or medical executive committees. Armed Forces hospitals usually refer the problem to the Judge Advocate and follow the procedures outlined in the Federal Tort Claims Act; Veterans' Administration hospitals rely on their regional office attorneys to handle malpractice.

Even those institutions with high insurance deductible amounts (making them partially self-insured) will follow this pattern, despite the fact that the institutions often participate in (or initiate) settlement proceedings for smaller claims out of court. It is common practice among malpractice insurance carriers to demand (and sometimes make as a condition of the policy) that *all* malpractice-related incidents be referred immediately to them without any actions taken by institution personnel. (Insurance carriers interviewed indicated that they were best experienced to handle, settle or defend cases and that inexperienced hospital staff intervening could take steps that would provide evidence in favor of the claimant.)

Two hospitals visited had offices that handled potential and actual medical malpractice claims. The JHH hospital in-house attorney has been discussed earlier in this report with respect to settling large billings with attached incident reports rather than submitting the bill and risking lawyer intervention.

In response to the loss of charitable immunity in 1965, TUH hospital established a PGM that is charged with dealing with all incidents involving actual, threatened or potential legal actions against the hospital arising from medical malpractice or malfeasance (according to the Director of this office, its primary purpose is to prevent litigation). Hospital staff refer all matters involving possible liability to this office and seldom, if ever, does it deal with minor, nonmedical complaints. It investigates and files all "incident" reports, serves as principal liaison with the insurance carrier, and has the authority to cancel bills and make direct settlements. For example, a bill was assumed for a patient who fell after being placed in an improper chair. The resulting hip injury was inoperable. Acting on the advice of the PGM, the hospital paid $15,000, and the insurance carrier assumed the $2,000 cost of rehabilitation.

Where the amount involved is substantial, or where the suit has already been initiated, the PGM will turn the matter over to the insurance company and its attorneys. Even in this case, the office may seriously consider recommending a settlement. If so, it becomes the carrier's principal hospital liaison for all fact-finding, provision of experts, etc.

For example, a patient admitted for a cataract operation suffered a perforation of a previously performed colostomy. All bills for additional time spent in the hospital and other expenses resulting from complications were cancelled, and a report was submitted to the insurance carrier. Despite the cancellation, the patient later initiated a lawsuit. At the PGM's recommendation, the insurance carrier arranged an approximate $30,000 settlement and the hospital suffered an estimated $7,000 loss.

These malpractice-oriented PGMs are unique to the universe of hospitals in the United States. This finding is supported by the mail survey which asked respondents to describe what ways the patient complaint function participated in resolving malpractice claims. An overwhelming majority said "No ways" or left the question blank. Those that answered typically said:

- Incident report completed with full details . . . and findings filed with hospital liability insurance carrier."
(Nonprofit hospital, 300-399 beds, Washington, D.C.)

- Review of report of visit; comments and discussion with interviewer by insurance adjuster, if desired.
(Nonprofit hospital, 400-499 beds, Pennsylvania)

- If a patient registers a complaint and states he is going to take legal action, the Patient Services Coordinator will investigate the problem . . . and apprise the Associate Director. She does not discourage nor encourage anyone from suing.
(Nonprofit hospital, 1,000+ beds, New York)

- "Assist in reporting claims, documenting incident reports, talking with patient and family to ascertain the central problems, notify administration."
(Church-operated hospital, 400-499 beds, Texas)

- "It is not often involved; in fact, usually the malpractice has too large a head of steam for the patient complaint procedure."
  (Unidentified leading hospital)

In summary, the usual process for handling malpractice complaints (or suits) against hospitals centers on the insurance carrier who receives incident reports and all suits from hospital administration. If PGMs become involved in the process, they serve as information gatherers, but most have little or no involvement with malpractice (or "serious") complaints.

III. Patient Grievance Mechanism Models

This chapter describes the "model systems" developed, the reactions to these models by knowledgeable individuals in health-related professions and the conclusions drawn about the utility of each model.[5] The refinements and supplementary concepts that resulted from the efforts undertaken during this phase form the backbone of the following chapter in which we present our specific recommendations to the Secretary's Commission on Medical Malpractice.

BACKGROUND AND INTRODUCTION

A basic purpose of this study was to utilize our analyses of the types of Patient Grievance Mechanisms presently operational, based on our on-site visits and the mail survey, to conceptualize a model Patient Grievance Mechanism, or system of mechanisms, that not only provides the patient with emotional support and a conduit for complaints, but also assists health care professionals with improvement of health care quality.

It should be emphasized that this process consisted of "testing" our concepts as assimilated into "model" Patient Grievance Mechanisms. The subsequent chapter on recommendations is the result of our analyses of reactions to the "models" set forth in Exhibits III-V and "tested" in this phase. We found that various features of the three "models" received different degrees of acceptance and we incorporated those findings into the system were recommended for a demonstration project.

Our Approach to PGM Modelling

The limited period of time for this phase of our study prevented us from installing and evaluating the several models in the optimal fashion, and the fact that few people had "thought through" and defined their mechanisms or what they felt were desirable further complicated the task. With these constraints we implemented our approach by

isolating the elements essential to Patient Grievance Mechanisms. We undertook to determine these elements from:

- our research findings and conclusions
- review of the literature related to patient grievance or complaint mechanisms (regardless of the title employed), and that related to ombudsman operations or conflict resolution devices
- discussion of these elements with "authorities" in the health care administration field

developing three generic Patient Grievance Mechanism models satisfying specific objectives. In simplest form, the development of models consisted of arranging the many elements of PGMs in logical patterns. Models were made as broad as possible so that expected negative responses such as "our health care institution is unique" and "no one model can be applied to our hospital" could be easily dispelled. We selected three models because the degree of difference between them was significant and each addressed a set of objectives that could be differentiated from each of the other models. Outlines for discussion of these models are attached as Exhibits III, IV and V

developing a "key factor list" of all major elements and sub-elements of Patient Grievance Mechanisms. After isolating all elements of PGMs, they were listed so that staff participating in our study on the behalf of health care institutions could assign relative values to each factor and, in essence, design a Patient Grievance Mechanism that best suited their needs. This list is attached to this report as Exhibit VI

selecting nine health care or related organizations to be visited, and scheduling interviews. A sample of organizations to be visited was selected on recommendations of nationally recognized authorities in health care and related fields. The directors of the organizations selected were telephoned and asked to participate in the study. We requested no more than three hours of interviews and suggested two separate meetings of one and one-half hours each. The first meeting was to include members of top administration, chief of medicine, legal cousel and a representative of the insurance carrier. The second was to include middle managers such as the head of nursing, director of volunteers, public relations director, head of social services and unit managers, if appropriate. This separation was designed to obtain two organizational perspectives on the use of a Patient Grievance Mechanism.

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[5] For the purpose of this study, "models" are general designs of mechanisms or systems that deal with patient grievances or complaints.

The types of institutions selected for visits were: hospitals (5), health maintenance organizations (2), a state planning board, a group insurance company and the Pennsylvania Office of the Insurance Commissioner *preparing and mailing a package of printed materials to each organization prior to our visits.* These packages consisted of eight copies of our three model Patient Grievance Mechanisms and our key factor analysis sheet. These materials were accompanied by instructions and a memorandum explaining the nature of the study (see Exhibit VII). The visits were made and the interviews conducted as planned. We received excellent cooperation from each organization and stimulated significant response from participants. These responses, including attitudes and opinions, were recorded and are incorporated in our analysis of the three models in the next part of this section.

Limitations of Methodology

Our methodology has four basic limitations that must be highlighted to keep our findings, conclusions and recommendations in the proper perspective. These four limitations are presented as follows:

The model PGMs have not actually been tested. While our interview approach provided perceptions of informed respondents, it does not provide an adequate substitute for actually installing several systems, providing them with the requisite technical assistance and evaluating them on a longitudinal basis against the original objectives stated.

Many respondents gave little thought to the models prior to our visits with them. In spite of our preparatory efforts and supportive letters from the Secretary's Commission on Medical Malpractice, little or no effort was made to utilize the key factor process to develop a system perceived as optimal by the respondents. Hence, much of our visit time was used to explain our study and details of the models previously mailed.

Our association with a Federal agency was a factor that made some respondents defensive. In some cases, we were perceived as either "selling" a concept or "evaluating" the institution to see how they addressed patient complaints. Allaying these misconceptions consumed more time and did not add to the substance of this report.

We were unable to assess important elements of each model because information is not available. Questions such as, What does a system actually cost? How much support will the Federal Government give us if we attempt to establish a Patient Grievance Mechanism? How do these mechanisms impact on "frivolous" claims?, could not be answered because no formal systems have been established and their results monitored and evaluated.

Despite these limitations the methodology utilized provided a reliable evaluation of the basic concepts and when combined with the mail survey and field research provide a base for the recommendations presented in the next chapter of this report.

The sections of this chapter that follow delineate the characteristics of each PGM model, and discuss the findings derived from our analysis of each of three models.

MODEL NUMBER ONE—BASIC LEVEL PATIENT GRIEVANCE MECHANISM

Model One most resembles those formal patient complaint functions we found to be operating in most hospitals. The basic objectives of Model One are to relieve top level administrators and professional personnel of the task of resolving "minor" complaints and to help keep patients in a positive frame of mind while in the institution.[6] For example, hospital administrators offered such justification as follows for maintaining such systems.

> "We want to take care of the entire patient and this mechanism provides emotional support to the patient."
>
> "These girls (airline hostesses) are a constant in the hospital. They see the patient soon after admission and try to visit each patient daily so the patient knows someone really cares."
>
> "These people serve as a liaison between the patient and his family and the professional staff of the hospital."
>
> "As nonprofessional problem solvers, these people can make sure the patient gets the basic services he is entitled to, such as hot food, clean sheets, prompt response to the buzzer, for his $130-odd per day."

An outline of this model, as presented to those we consulted in the field, is attached to this report as Exhibit III.

Coverage

The Model One patient grievance office would need adequate staff to make personal visits to all patients in the health care institution except psychiatric wards and extended-care facilities not physically attached to the institution. Since many patients have negative feelings and yet do not complain, Model One staff make contact with noncomplaining patients as well.

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[6] As used here, "minor" complaints are typified by complaints about food, laundry, service, housekeeping service, etc. (See Exhibit VI.)

The patient would learn of the existence of the patient grievance office from admitting personnel and from a booklet describing the office. The booklet would explain the function of the patient grievance office and the type of problems it is empowered to address. In addition, its telephone number would be displayed prominently in each room. This obvious publicizing of the office is important for two basic reasons:

- the channels through which complaints flow should be centralized for both control and tracking purposes
- the patient should be able to complain without having to call upon a nurse or physician. Many patients withhold complaints during their stay because they depend on the subjects of their complaints for their well-being in the hospital. This suppression of complaints may be unleashed after the hospital stay by a high bill or slow healing and result in a claim or suit against the institution or individual physician.

Complaint Communication Channels

Although the Model One system is designed to reduce the plethora of complaint channels, patient dissatisfaction will be communicated to the patient grievance office staff in several ways including:

- direct patient telephone calls, coupled with a portable signal device ("beeper") to ensure rapid response
- direct patient contact during systematized floor ward visits
- referrals from staff at the professional and nonprofessional levels who complain about "grumpy" or "uncooperative" patients
- referrals from family or visitors to whom the patient complains
- referrals from a reception desk or outstationed office (particularly clinics and outpatient departments)
- referrals from other administrative personnel if a patient deliberately bypasses the patient grievance office because he perceived it as "powerless" or a "public relations gimmick"
- patient responses to post-stay questionnaires or letters written following their discharge.

The location of the patient complaint office could be an important factor in successful complaint communication. This office should be easily accessible to patients and visitors to the institutions.

Complaint Resolution Process

The assembly of facts relative to a complaint and their analysis are functions of the patient grievance office in Model One. In short, a representative of the patient grievance office:

- investigates the substance of the complaint by
  - interviewing the patient
  - collecting the relative information
  - interviewing staff involved
  - inspecting the premises or monitoring the process during normal operation
- determines if the claim is meritorious and, if it is meritorious, reports it to the head of the service in question (e.g., nursing, dietary, housekeeping, safety). Documentation of findings should be provided along with recommendations, and the corrective action should be monitored and evaluated
- explains nonmeritorious complaints to the patient and explains what situations exist that preclude taking corrective action.

Organization Position of Office

Organizationally, the Patient Grievance Mechanism described in Model One should report to the second level of management (assistant or associate administrator). In our experience it is normal for the head of this type of Patient Grievance Mechanism to report to the third (head of service) or fourth (head of division within a service, e.g., head of private nurses) level of management. Reporting to the second level of management should give the office needed access to all institution departments.

To operate effectively this mechanism must have access to a patient's medical charts, should see all accident-incident reports, and must be able to obtain investigatory interviews with institution staff as needed. The office, as we perceive Model One, should be expected to recommend personnel terminations or reassignments, recommend changes in billings if discrepancies are found in charges for services and to recommend changes in institution processes that are causing suboptimal patient service and/or health care.

Patient Grievance Office Staffing Pattern

The staffing pattern should consist of three full-time employees and a part-time secretary per 250 beds. We anticipated the following compensation levels based on salaries paid to existing positions of similar responsibility:[7]

- $8,000 annually for the office head
- $6,500 annually for the other two full-time staff
- $4,000 for clerical support staff.

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[7] Based on observations of pay scales for this type of system in two major metropolitan areas.

The patient grievance office head would typically be a woman with some nursing or health care administration background who could "empathize" with the patients. She would have the ability to "get along with people" and to "coax nonprofessional people to change their ways without a confrontation."[8] One staff person should be primarily responsible for the emergency department and the outpatient clincis. The number of staff should vary directly with the size of the institution. The effort should also be augmented by volunteers.

We envision the head of the office being selected by her immediate superior and that she would typically be someone with prior experience in this hospital (particularly in nursing) or in another health care institution. The other two staff should be selected by the office head and would probably resemble the profile of an airline hostess.

Other Responsibilities

In addition to receiving and identifying patient complaints, investigating them and suggesting necessary changes in health care delivery systems, the Patient Grievance Mechanism head should:

- analyze post-stay questionnaires and letters to
    - spot unfavorable trends, investigate and recommend corrective action
    - identify areas receiving praise, determine the reasons and publicize meritorious actions
    - respond to specific written complaints
- sit as at least an ex officio member of patient care (or the equivalent) committees
- assist in placing individuals in extended care facilities as rapidly as their medical condition permits to improve facility utilization and to contribute to a better use of health care insurance
- participate in the public relations activities of the institution.

Under this model all complaints alleging malpractice would be referred to administration, the insurance carrier and institution legal counsel. The patient grievance office would not be responsible for settlement of these claims.

Interview Responses to this Model

The overwhelming majority of respondents felt Model One was "too expensive for the benefits that accrued," to quote one hospital administrator. Illustrative of the negative reasons given are the following responses:

- "The 'airline hostesses' would not have the necessary background to analyze or understand the total health care situation."
- "It's a waste of money because malpractice suits do not result from a broken cookie under the bed."
- "Such a system buffers the administrator too much and he loses touch with what is going on in the bowels of his organization."
- "The money used for such an office could be used far more effectively to provide in-service training to all staff on how to identify with the patient and to respond to his emotional needs. Also, the staff could be taught or motivated to respond when the patient stretches out his hand."
- "We tried something like this before and all it did was stir up the patients and antagonize the physicians." (Note: in this situation the person who held the position was a three-time divorcee and well-known socialite with no medical experience.)

The emphatic rejection of Model One contrasts strikingly with the fact that many health care insitutions utilize Patient Grievance Mechanisms similar to Model One.

The ambivalence of attitudes toward Model One is exemplified by one respondent who strongly condemned the "model" during an early part of the interview and subsequently praised his institution's chaplaincy service because it "ferrets out people's complaints, changes light bulbs and generally helps out the professional staff," a role quite similar to that of the Model One PGM, only based in the chaplain's office. In essence there were mixed reactions among the respondents as to (a) whether the minor complaint "triggers" a malpractice suit, and (b) whether the "cookie under the bed" problem is important enough per se to justify a mechanism. It is also worth noting that respondents' perceptions of the value of such systems varied with their own respective hospital positions.

Given the strength of the opposition to Model One, the criticism centered on three primary elements:

- heavy promotion of the patient grievance office and giving a patient a booklet describing the process would only "cause" complaints
- the individuals responsible for the hospital "unit" should handle their patients' complaints and they should not be filtered through "another bureaucratic layer."
- the compensation range was unrealistically low and hospitals would not realize savings from this function to offset its cost.

However, two points that were made repeatedly were that:

- a strong orientation program would be required if such a PGM were to succeed and if the staff were to make effective use of the function
- the PGM must be careful not to become the "scapegoat of last resort" for departments so that they "pass along the difficult and somewhat embarrassing problems."

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[8] Quoted as prerequisites of the job by an administrator with a system substantially similar to Model One.

Conclusions

Our inquiries in this phase and our earlier examination of existing Patient Grievance Mechanisms in 20 health care institutions make clear that Model One has limited appeal. However, this model could be useful to institutions operating under the following conditions:

- An active social service and/or volunteer services department does not exist and there is a need for an individual to perform social and nonmedical services for patients.
- This function substitutes for a public relations department and provides external PR as well as internal patient relations services.
- The institution is located in a densely populated, lower income community whose citizens make heavy use of the emergency room and outpatient clinics. The Model One office, in this situation, is responsible for communicating the patient's needs to hospital staff and helping the patient understand the health care delivery process.
- The institution is large with many different functional units that operate separately from one another. The Model One office acts as an "objective" observer calling attention to interfunctional problems. In this sense, the office becomes a "troubleshooting" function that studies the problems resulting from poor interface between hospital functions.

In summary, we found that Model One is perceived as cosmetic and superficially related to the malpractice problem in health care institutions, and that its staff are not professionally qualified to handle malpractice cases. Those institutions that have formal functions similar to Model One have not conducted cost benefit studies and no data relating this function to malpractice suits was found. Therefore, we conclude that Model One does not represent a proper allocation of funds and is, at best, of marginal value in reducing malpractice problems in health care institutions.

MODEL NUMBER TWO—COMPREHENSIVE INTERNAL PATIENT SERVICES DEPARTMENT (PSD)

Model Two expands the authorities and responsibilities of the patient grievance office outline for Model One and assumes the added responsibility of investigating and resolving medical malpractice and negligence claims. Since Model Two has a broader service coordination mandate within the health care institution, "Patient Grievance Mechanism" is not fully descriptive of the role and "Patient Services Department" is a more appropriate title for the Model Two function.

An outline of this model, as presented in the field, is attached to this report as Exhibit Two.

Model Two Objectives

Model Two has the following objectives:

- to investigate the matters patients complain about and to introduce needed changes into the delivery pattern in an effort to reduce malpractice claims and improve the quality of care
- to utilize the existent resources of the institution to reduce the patient's feelings of "isolation" and negate the "dehumanizing" effect of a hospital stay
- to examine incident reports, unusually high bills, and to analyze data relevant to claims made against the hospital in order to rebut frivolous claims and document institution and physician negligence when it occurred and recommend courses of action. These recommendations may vary from remedial care for the injured person, to termination of the offending individual, to settling for an "equitable" amount out of court.

Coverage

Model Two requires that the Patient Services Department be responsible for the resolution of all complaints, regardless of their origin or nature. The personal contact with patients may not necessarily be provided by Patient Services staff, but by the staff of existent departments who can best resolve the particular complaint. The Patient Services Department is the coordination point for resolution of the complaint and "orchestrates" all actions taken.

Each patient would receive a booklet at admission describing the patient's rights (e.g., acceptable level of care, informed consent, etc.), and what the patient can legitimately expect from the institution (e.g., the reponse to buzzer calls, the type of food, the degree of personal attention by the physician, etc.). In addition, the booklet would describe:

- whom to notify and the proper procedures if problems arise
- the grievance investigation and resolution process
- the limitations of the internal mechanism's resolution process (e.g., that it would not recommend award of "pain and suffering" or similar damages).

Complaint Communication Channels

In Model Two patient dissatisfactions are communicated in the following ways:

- use of a standardized complaint form that would be provided along with the booklets provided at admission. The form would be designed to record information such as:
    - type of complaint

- parties involved
- number of times error repeated
- people aware of the problem and those who had discussed it with the patient.

The form would be precoded to allow for computerized trend analysis and cross-tabulations for large institutions. However, it would require some open-ended sections to get the patient to describe the problem in his own words. Volunteer and social service staff should be trained to assist in completion of these forms

- posting of the office's telephone number in a prominent place in all patient rooms and hospital clinics. The telephone system should be connected to a "beeper" system to ensure optimal response time
- review of all incident reports and copies of all legal correspondence should be sent to the office
- assignment of individuals under the adminstrative control of the office to make ward visits in an attempt to identify potential problem or complaint areas
- stationing of "paticnt service centers" in the emergency department and near the main entrance of the institution to "pick up" complaints from family, visitors and future patients.
- encouraging of staff to identify "difficult" patients so that special attention could be given to them when required
- use of post-stay questionnaires that the office would prepare, send out and analyze. These would be designed to elicit criticisms of the system's operations and praise for appreciated services
- forwarding of copies of bills 60 days overdue to the office for review.

Although we contemplate that all complaints would be communicated to one central office, we recognize that other channels will operate and would have to be integrated into this system on an informal basis.

Complain Resolution Process

The key to the office's effectiveness, in our opinion, is the way it receives complaints, investigates them, and takes or recommends the appropriate responses. The steps of the investigative process for minor grievances and for complaints of alleged malpractice are outlined as follows:

for minor complaints that are obviously not directly related to malpractice, the Patient Services Department would

- discuss the situation with the complainant
- review the patient's medical records
- review the files of similar complaints to see what steps had been taken previously
- discuss the situation with staff involved or implicated
- analyze the information
- take action where empowered to do so with respect to meritorious complaints (e.g., write off part of a bill, or make recommendations to department heads with respect to process changes, personnel changes or disciplinary action)
- when complaint is judged to be nonmeritorious, return to patient and explain investigation, results and conclusions

for complaints that stem from possible negligence or medical malpractice the Patient Services Department would:

- summon an ad hoc committee including physicians, administrators, insurance carrier representatives and other staff whose opinions are needed to consider the specific complaint
- gather data for this committee's consideration including documentation of what had been done, what the patient perceived had been done and the underlying rationale for the claim
- participate in the committee meeting, interjecting the patient's viewpoints, thereby ensuring that the committee maintains a humane and realistic perspective of the case
- coordinate full investigation of incidents with insurance carrier representatives
- upon decision of no fault, document the evidence that led to the decision and inform the patient
- refer a dissatisfied complainant to the local bar association's lawyer referral service
- if fault is detected, work with the insurance company representative to develop a settlement that is fair to all parties involved (e.g., the patient receives remedial medical treatment at no cost and the rest of the bill might be "written off' to offset "pain and suffering" and yet not allow the institution to become known as a "soft touch").

Model Two provides through the processes listed above the comprehensive system for the fact finding and assessment that is required for fair and equitable resolution of patient dissatisfactions.

Organizational Position of PSD

The Model Two organization would be funded by the institution and would be "institutionalized" through the by-laws of the institution. The Patient Services Department would be headed by an associate or assistant administrator (second level of management) who would report to the administrator and/or the governing board of the institution. The Patient Services Department has a strong coordinative responsibility and should be responsible for the functions indicated in the diagram on the following page.

Authority of the PSD

A key difference between Models One and Two is the degree of authority each office has. The Model Two office would have more "clout" and would have the authority to:

- require attendance of staff at investigatory ad hoc meetings.
- review all hospital records as needed
- "write off" bills at amounts up to the insurance deductible limit where such action was determined to be equitable and in the institution's best interest
- authorize free care when an investigation of a complaint indicated that it was deserved
- organize the units under its administrative control to deliver the best possible service and obtain approval from the administrator, patient care committee and the governing board (when required)
- undertake studies into how effectively and efficiently all aspects of the institution or program operate and recommend changes that will improve the quality of care or reduce malpractice claims
- negotiate monetary settlements for claims prior to litigation if
  - the claim including medical bills and "pain and suffering" will not reasonably exceed $25,000
  - no further pain or discomfort or need for medical care related to the claim is likely to occur.

Individual institutions or programs may grant the office additional authority and responsibilities depending on the unique organizational characteristics and the staffing patterns of the office.

PSD Staffing Patterns

The staffing pattern we envisioned for the Model Two Patient Services Department included:

- an office or director well-versed in institution or health program administration and with a law degree or a background in insurance ($25,000 annual salary)
- "patient representatives" of the same qualifications as those described in Model Number One, i.e., the "airline hostess profile" (eight at $6,500 annual salary)
- registered nurses used in the emergency department and the intensive care unit to serve as conduit of complaints and provide "spot assistance" in acute medical situations (four at $9,000 annual salary)
- clerical staff as required to maintain records and prepare reports (two at $6,000 annual salary).

The cost of the unit would vary with the size of the institution, but for a 500-bed hospital the PSD is estimated to cost $125,000 annually, as indicated by the above calculations. These figures are based on our analysis of salary data gathered during our on-site visits.

Recognizing the significant cost and the financial constraints most health care institutions are facing today, smaller institutions should consider consortial arrangements for PSD directors. Another advantage of such consortial arrangements is greater impartiality from the ad hoc committees if staff from consortial institutions were used in the process instead of peers from within the institution against which a claim was being leveled.

Other Responsibilities

The PSD director of the system described in Model Two should be a voting member of the following committees:

- patient care
- utilization
- ad hoc investigating committees
- management (where it exists)

and an ex officio member of the "tissue" committee.[9]

The staff of the office should assist in transferring patients to extended-care facilities upon approval of the attending physician.

Special studies should be conducted into how the institution could operate more effectively, provide better care, reduce the number of accidents and incidents that resulted in claims, and increase overall patient satisfaction. A subfunction might well include orientation and education programs for staff, patients and the general public.

Interview Responses to Model Two

The majority of respondents felt the Model Two concept and objectives had *merit.* The primary values cited were:

- It would alleviate some of the pressures on top administration to isolate problem areas in the institution and to document what health care system changes are needed.
- Two respondents felt the effectiveness of the office would be further enhanced if it were given responsibility for in-service educational programming for all staff, emphasizing that "caring is part of the cure."[10]

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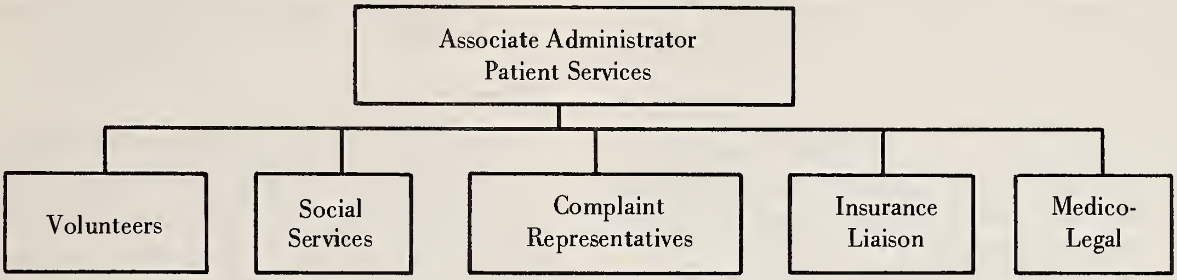
[9] A "tissue" committee is defined by the AMA as a group of medical doctors that evaluates the tissue removed through various surgical procedures and makes a report on its findings.

[10] A slogan currently being used by the Johns Hopkins University Hospital.

MODEL TWO FUNCTIONAL ORGANIZATION



- The PSD could be useful because it could bring together the functions of nonprofessional care to the patient (i.e., volunteers and social services) and those responsible for the dealing with dissatisfied patients (i.e., insurance and legal services). One respondent suggested dietary, maintenance and housekeeping should also be included under its control. A majority of the respondents felt the chaplaincy or pastoral care department should be included.
- The PSD, if correctly staffed, could promote both better insurance carrier relationships, as reflected in lower premiums, and more satisfied patients because of rapid response to their concerns.
- The office could compromise on a bill with an angry patient and, to quote one person, "This function addresses the patient where most post-operative pain is—in the pocketbook."
- The PSD would serve as a "horizontal" linkage of the many institutional departments, e.g., outpatient, Ob-Gyn, found in large hospitals.

Concerns voiced about such an office by some respondents include the following:

- the fear that the staff in the office would begin to interface with the physician-patient relationship. To quote one respondent: "The temptation will be there for my office to jump into every situation when a patient voices a complaint."
- To avoid organizational friction the office staff should deal primarily with department heads, and contacts lower in the organization should be approved by department heads.
- It would be a case of "biting the hand that feeds you" if the office were to refer dissatisfied patients to attorneys. (It should be noted that a discussion of "equity" and "patient rights" had little impact because most respondents felt too many suits were being filed already.)
- There was concern about the cost of the office, but many respondents commented that by playing its "coordinative" role the operation really provided a line function that was needed.
- One concern voiced repeatedly was the difficulty of finding the *right* man to head the office. Assuming that the establishment of such offices might be supported by Federal funds, several respondents were skeptical of the supply of qualified people. These considerations led to discussion of the merits of a "specialized curriculum designed to prepare people for this job" versus putting on in-service education programs for professional and nonprofessional staff. Also, some respondents felt that in-service training coupled with the new "humanistic" medical education curricula would "eliminate the need for the office in ten years."
- One respondent initially questioned the value of the system given that it was "not binding on either party." After two hours of discussion he conceded it *might* be beneficial if effectively staffed so that it established a reputation for objectivity and would "scare off the ambulance chasers."

In spite of these concerns most respondents felt the system set forth in Model Two would benefit the health care institution and its functioning in both the long and short term. In addition, several respondents stated specifically that it would give the consumer (patient) a "fairer shake."[11]

Conclusions

The responses of model "test" participants make clear that the system described as Model Two has substantial merit. This conclusion is further supported by the advice of two administrators with similar PGMs visited during phase one field work who commented that their PGMs were "worth their weight in gold" and "invaluable assets to the institutions."

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[11] The one person who disagreed with the system entirely admitted that he was "prejudiced because of a prior bad experience with such an office."

The Model Two office should provide counsel for injured patients who could not be properly handled by the system, and its staff should serve as witnesses for the patients as required. We must conclude, based on an analysis of the responses we received, that this service would probably not be well received by most health care institutions and most insurance carriers.

Most respondents felt Model Two would be productive in *most institutions*, and several commented that it was viable because "it has a chance to pay for itself by reducing the amount payed out in claims, for court fights and for insurance." They also commented that, "Model Two fulfills the roles of in-house council, patient services coordinator and internal insurance representatives."

We conclude, also, that Model two can have utility that outweighs its costs, if properly staffed and given the requisite authority, in institutions with 250 beds or more. For smaller institutions consortial arrangements are possible, and in very small institutions, isolated from others, the duties described above could be assumed by a top-level committee of administrative staff on a rotating basis. This type of office appears to have potential to gain widespread voluntary acceptance in health care institutions and to impact favorably on the quality of health care delivered. It should help reduce the number of claims and the real dollar cost of insurance while improving patient satisfaction.

MODEL NUMBER THREE—LEGISLATIVELY BASED OMBUDSMAN

Model Three developed out of a perceived need for an external, independent office that could "oversee" and evaluate the processes employed by health care institutions to respond to patient complaints and concerns about medical treatment. This model provides the "objectivity" that functions funded by the institutions they monitor cannot claim.

At the outset of this discussion it should be noted that we encountered a good deal of confusion about the meaning of the term "legislatively based ombudsman". The term was intended to mean an office, in the executive branch of government, specifically authorized by *state* statute. As a result of this confusion, and because "ombudsman" technically refers to a legislative rather than to an executive position, we will refer to the model as a State Health Complaint Office (SHCO) in this discussion.

An outline of this model is attached to this report as Exhibit V.

Objectives

Model Three has two primary objectives:

- to help resolve malpractice and negligence claims through investigations of such claims
- to analyze trends on a state-wide basis, identify "trouble spots" and recommend changes in the health care delivery system that would eliminate these problems.

Coverage

Under Model Three the ombudsman would receive all malpractice and negligence claims arising from physician treatment and that delivered by any health program or institution within the SHCO's jurisdiction. In other words, all health-related negligence claims or lawsuits would fall within the purview of the ombudsman.

The SHCO should provide all institutions, for distribution to patients, a booklet describing patient rights, and parameters of expected levels of health care quality.

Complaint Communication Channels

The SCHO, under this conceptualization, would become aware of complaints, dissatisfactions and problems by:

- having patients forward a standardized complaint form to the ombudsman. This form would be included in the booklet to be disseminated at admission
- communicating informally with health care staff, insurance companies and lawyers about claims and potential problems
- analyzing malpractice and negligence lawsuits that have actually gone through the litigation or arbitration processes.

This process is broader in scope than in the other Models because it examines on its own initiative complaints, trends and processes. The SHCO receives complaints, but does not solicit from noncomplaining patients their view and opinions of treatment.

Complaint Resolution Process

The SHCO would conduct in-depth fact-finding of all claims that come to its attention. To do this effectively, the office would:

- have access to all institutional and physician records
- analyze these records with all data on the specific claim available to him
- interview all parties to the claim as necessary to ascertain the facts
- draw on the state medical societies to provide "experts" to examine any relevant medical material. These physicians would not be from the institution or program against which a claim had been levelled
- reach conclusions based on analyses and inform all parties of decisions. At this

point, the SHCO would take one of the following steps:

if the claim was found to be meritorious, the office would assist the plaintiff in finding counsel

if the claim was found to be meritorious, the office could recommend a damage settlement and/or cancellation of bills

if the claim was found to be nonmeritorious, all parties would be officially informed of the decision and the supporting documentation.

Special Authority and Responsibilities of the SHCO

The SHCO would have subpoena power to obtain relevant testimony from recalcitrant witnesses or institutions. In addition, the SHCO would be empowered to:

- recommend the level of payment in situations where the claim was determined to have merit
- recommend the cancellation of bills in instances where the facts justified such an action
- conduct analyses of the health care practices of the state and offer suggestions of ways to improve the provision of medical care to institutions and to the legislative body
- conduct hearings to investigate major health care problems that exist throughout the SHCO's jurisdiction.

All of the investigatory analyses would be presented in an annual summary report to the governor, the legislature and the people.

Staffing Pattern

An important determinant of the SHCO's success is the adequacy of the staff provided. Examining of the functioning of the Scandinavian ombudsman system demonstrated the importance of effective staff in carrying out the activities of this office. The staffing proposed for Model Three would include:

- a director who is respected by the medical institutions and programs within the state. The individual should have had a background in health administration and have been trained in the law. We envisioned that the caliber of individual required would command a salary of approximately $40,000 annually
- staff with backgrounds in law, health programming, health administration, insurance and extended-care facility administration. The ratio should be one professional staff per 1,000 beds and should be selected from the geographic area where support is needed. We estimate salaries from $17,000 to $22,000 for these staff members
- clerical staff and administrative interns would be hired as the work load dictates.

Application of these guidelines would mean the annual budget of the SHCO would not likely be less than $150,000 and in the larger and more densely populated states would be greater.

Other Responsibilities

Besides serving as the "ombudsman" in the health care field the individual should serve as an advisor or ex officio member to at least:

- the state licensing board
- the state board of health
- the educational board examining medical education
- health care accrediting groups
- the state insurance commissioner.

By expanding the "ombudsman" duties to include these areas, his (a) information sources are improved, (b) scope of activities is broadened and (c) findings and conclusions are assured of receiving the widest possible dissemination.

Interview Responses to Model Three

Few respondents we consulted understood the proposed role of the SHCO described in Model Three. The concept, it was claimed, was "foreign" to them. After several false starts, we were able to evoke meaningful responses by equating the office conceptually with an Office of Consumer Affairs such as the one in the White House.

Several significant findings voiced by the respondents are outlined as follows:

- Each health care institution would have a patient grievance system of its own that communicates with the ombudsman.
- The SHCO should be beneficial because it serves "as a high level screening panel, and if staffed with a man everyone respects, the plaintiff's attorneys will not touch a case the office has found to be nonmeritorious." Another respondent simply stated that "by screening these complaints the number of nuisance claims should be reduced to zero."
- Several respondents felt the "overview" or "bird's-eye view" would be useful. Most of these respondents felt the office should report publicly on the "good and the bad" of health care delivery systems.
- Special subjects for broad analysis of health care problems according to most respondents included
  equipment and space utilization
  extended-care facility availability
  training program availability
  weaknesses in training as evidenced by the number of incidents.
- Several respondents felt that the SHCO should "try to educate the public so that their expectations are realistic."

In general, we found that most respondents felt that the SHCO concept had merit. However, these findings should be related to the fact that relatively few (under 25%) had thought deeply about the SHCO approach to patient grievances until after we initiated our discussions with them.

A number of respondents voiced concerns and raised the following questions:

- To what degree does the SHCO duplicate the work of
  - the state and area health planning boards
  - the state health board
  - the Joint Commission on Hospital Accreditation
  - the insurance commissioner
  - the licensing board
  - the various medical societies?
- Would the SHCO be a governmental "spy" and perform an enforcement role? This point was made most pointedly by the Nebraska State Ombudsman who stated that the traditional ombudsman is a legislative creature and an "overseer" while an "enforcer" is a product of the executive.
- Could the right man or woman be attracted to the job at the suggested salary?
- What specific safeguards would be enacted to keep the ombudsman from "becoming a political football or hatchet man" for the chief elected official?

The main weakness that most respondents identified was the inadequacy of an information system that "would ensure that the SHCO really knows what is happening at the local level." This criticism was accompanied by suggestions, such as:

- having the SHCO get copies of all complaints filed at the local level
- requiring that all settlements of more than a specified dollar amount must be reviewed by the SHCO before being awarded
- requiring that all incident reports and subsequent investigative materials be sent to the SHCO at the time they go to the insurance company
- requiring that a computerized management information system be designed so that data could be collected periodically and undergo constant analysis.

Conclusions

While the SHCO system has some drawbacks, our field inquiries suggest that

- the ombudsman approach outlined in Model Three is functionally sound and acceptable if:
  - it is properly staffed
  - it receives the information it needs on which to base its investigations and trend analyses
  - the insurance companies and medical societies agree to cooperate
  - it serves as a screening panel to help reduce unjustified malpractice claims
  - the responsibilities of the SHCO are clearly defined so as not to duplicate the functions of other agencies
- there is a need for a high level office to which the public can complain directly about medical care problems. This office will then be required to objectively evaluate the situation and render an equitable judgment
- the SHCO will function most effectively if local level patient grievance mechanisms work in a systematic way with this office.

SUMMARY OF REACTIONS TO MODELS

The officials of health care institutions whose reactions to alternative Patient Grievance Mechanisms were sought out voiced opinions forthrightly and clearly, making it easy to identify a consensus on all models. A brief summary of those views is presented below.

Model One

Model One was rejected by almost all respondents because:

- it offers "marginal cost benefits" and performs functions that professionals and staff should be performing.
- the funds utilized for this model could better be utilized for in-service education and orientation for the staff to improve staff-patient relationships and, therefore, improve communication and resolution of dissatisfactions
- this system creates an added layer of "bureaucracy" of questionable need and marginal value
- the lack of professional training for the official in charge under this model serverely limits the utility of this approach in health care institutions.

Model Two

Model Two was generally received favorably. Most respondents indicated that a central complaint gathering and analyzing office would have value. However, most respondents claimed that their institutions had to have mechanisms designed to fit their unique characteristics and that if a single design were recommended by a Federal commission, it might have little impact. It is our opinion that, although there are distinct differences in each health care institution, a basic model that could be adapted with relatively little difficulty to almost any health care institutions or program can be recommended. In summary, Model Two

- deserves consideration and probably can be adapted in most institutions to such unique institutional characteristics as exist
- provides the degree of professionalism in staffing at the topmost organizational level of the institution that promises effective handling of grievances
- provides for essential coordination; several respondents felt that it should focus on coordination of services rather than on specific complaint resolution.

Most respondents stated, and we concur, that evaluation techniques must be developed to ascertain how well Model Two functions under "real life" conditions. These techniques should address the vital issues including number of incidents, claims, suits, size of insurance premiums, and level of patient satisfaction.

Model Three

A majority of respondents felt that Model Three has potential value. However, some voiced the opinion that this function was already being performed, at least to some degree, by such existent agencies as the State Health Commission or the Insurance Commission. Once this unit was compared with an Office of Consumer Affairs most respondents felt that it had merit. There was some fear of the governmental presence that this might entail, but an SHCO that would serve as a channel for health care complaints was generally accepted. While there was a consensus in support of the Model Three concept, the implementation of the SHCO should be approached with extreme caution.

In conclusion, our several analyses of alternative "models" suggest that there is general acceptance of the concept of a patient complaint or patient grievance function. Most institutions expect such a function to "pay for itself" in some way, whether this be by reducing insurance premiums, reducing malpractice suits, reducing incidents, or improving patient satisfaction so that more gifts are given on an annual basis. Opposition by health care staffs to such offices does not appear strong; a minority of the respondents would not consider using a patient grievance mechanism unless mandated to do so through Federal funding requirements.

In the next section of this report, we recommend steps that can now be taken to move toward the establishment of formal patient grievance systems. It should be reiterated that the "models" tested in this phase of the study were but one of several information sources utilized in the development of the system recommended in the subsequent chapter.

IV. Recommendations

The recommendations presented below are based on analyses of information collected through (a) on-site visits to health care organizations with PGMs, (b) our mail questionnaire and (c) our "model testing". The system of mechanisms recommended draws from all three sources for its component parts and structuring and differs substantially from those "models" presented in the preceding section.

ASSUMPTIONS UNDERLYING THESE RECOMMENDATIONS

To successfully carry out these recommendations, the following basic assumptions must be made.

- Enabling legislation will be passed on the appropriate governmental level to authorize the formation of all required organizations and permit them to operate.
- A component of the Department of Health, Education and Welfare will be given the responsibility, authority and funds required to conduct the demonstration projects.
- There will be some Federal financial support for technical assistance and evaluation component design.
- The following will agree to support the implementation of these recommendations:
  the medical profession
  the organized bar
  insurance carriers
  consumer groups.
- The personnel needed to adequately staff the recommended systems can be found in today's labor market.
- The system we suggest will result in cost savings over time by reducing malpractice suits, and therefore premiums and defensive medical charges.

These assumptions are important to swift and successful implementation of the following recommendations and should be studied prior to the implementation of any PGM system.

RECOMMENDATION ONE: A DEMONSTRATION

Some past failures of Federally funded programs have been attributed to nationwide implementation without testing alternative approaches. Hence, we suggest that, before a system of PGMs is prescribed, a system with alternative component parts be thoroughly tested. Our research indicates that a system such as the one recommended would benefit both the institution and the patient, but additional performance and cost benefit data is needed before the system should be mandated in all health care institutions.

We recommend that DHEW sponsor a demonstration program that provides financial support and technical assistance for design and implementation of pilot Patient Grievance Mechanisms.

The need for undertaking demonstration projects arises from the following facts.

- Adequate quantitative data as to how well the existing systems operate, that would permit definitive judgments of their relative effectiveness, is not available.

- The concept of a PGM is not generally understood nor accepted; clearly enunciated objectives for such systems should be promulgated and a program of dissemination pursued.
- A number of alternative systems need to be "costed out" under "real world" conditions to provide some basis for future planning and budgeting.
- Although many PGM structures and staffing patterns exist, the lack of agreed-upon objectives and standards makes it impossible to measure effectiveness.
- Few, if any, studies of patient satisfaction with institutions, or studies of the degree to which a PGM improved patients' attitudes toward health care treatment, exist.

Other reasons for instituting PGMs on a demonstration basis prior to "going national" could be cited. The foregoing reasons adequately support the need for a demonstration and testing program.

Suggested Demonstration Projects

We suggest that the demonstration projects DHEW undertakes should include:

- *design and implementation of an evaluation system for two existing PGM systems* that would be expected to continue their existing operations without significant redesign. Our research found a number of systems that may be appropriate for this demonstration
- *design and implementation of at least three systems in institutions that do not now have formal patient complaint functions.* Each of these should be in different size hospitals, each with a different mix of medical services (i.e., one with large OPD and emergency room; one with longer-term patient care, etc.). Also, the directors of each of these demonstrations should have different backgrounds: one should be a lawyer, one a hospital administrator or medical person, and one should have specific background in insurance. The effectiveness of each office can be measured and the problems relative to specific systems variables can be recorded to provide valid data for future development of PGM models
- *design and implementation of one state-wide system similar to Model Three presented in Chapter Three of this report.* To locate a possible candidate for this demonstration we felt it desirable to minimize the cost. We searched the American Hospital Association's 1972 *Guide Issue* and decided that New Hampshire would be an optimal state because minimal dollars would be required and because it is of reasonable magnitude for evaluation purposes. New Hampshire has only four health care institutions with more than 200 beds, the minimal size we recommend for an individual institution patient grievance system, and its geographical size would simplify the task of establishing consortial arrangements to provide PGMs for patients in smaller institutions.

We estimate an annual cost of $75,000 for each of the four individual PGMs ($300,000), and $50,000 annually for three consortial PGMs ($150,000), and $75,000 for the state office, bringing the total annual cost, including technical assistance and evaluation ($75,000), to approximately $600,000. Without evaluating funds availability, this appears to be a reasonable outlay to demonstrate and measure effectiveness of a state-wide system. These figures are based on discussions of required salaries to get the type of people needed in major metropolitan areas throughout the country.

The estimated total costs for this suggested *demonstration effort* for a one-year period are outlined as follows:

- approximately $600,000 for the state-wide system in New Hampshire
- approximately $300,000 to design, implement and manage models installed in three health care institutions
- approximately $50,000 to establish evaluation systems in two existing systems
- approximately $100,000 to design a centralized, automatic input/evaluation system
- approximately $75,000 for on-site technical assistance.

Thus, the total cost of this demonstration project would be just under $1.2 million. However, since we expect cost savings in the areas indicated earlier, e.g., malpractice premiums, defensive medical charges, etc., the *real cost* is difficult to estimate.

Other Considerations

A number of other considerations that will affect the utility of the demonstration projects exist. For example:

- The mechanisms that are designed and put in place must be used by patients with complaints. Limited use of the, PGM would either (a) make it abundantly clear that such systems were not useful because patients looked at them with suspicion or (b) totally invalidate the research findings expected from the demonstration projects.
- In the planning stages specific goals and quantifiable objectives must be formulated against which performance of the mechanism can be measured.
- The evaluation system must be reliable, valid and have utility as a predictive mechanism. During operation the PGM organization must be flexible enough to change in the directions evaluation indicates would be

more effective. We suggest that the input portion of the evaluation systems include data such as:

the number and kind of patient complaints. These complaints could be recorded at the institutional level on precoded forms, with adequate space provided for the patient to enunciate his problems in his own words

the number and kinds of incidents reported

the number of malpractice suits classified by type of health care service

the record of settlements out of court

the results and dollar awards of claims that actually went to court

the degree of patient satisfaction with the institution and its component parts. Measurements of this satisfaction could be obtained:

a) from a post-stay questionnaire specifically designed for this purpose
b) from a tracking of the number of patients who came to the institution because a former patient recommended it
c) by tracking the percentage of patients, and changes in that percentage, who contribute to the annual giving campaign
d) by interviewing a small randomly selected number of patients shortly after they get out of the institution or program

the change in insurance premiums.

- Baseline and historical data for these factors should be collected prior to implementation of the demonstration projects. It is essential to realize that the evaluation must also consider qualitative factors related to the objectives, and a careful eye must be kept on unanticipated influences such as staff friction, management style and unforeseen events (floods or train wrecks).
- Constituencies of the PGM must support the demonstration project (e.g., the AMA, AHA, nurses, house staff, etc.). This may be most difficult because of the basic negative attitude toward anyone interfering with the physician-patient relationship and the feeling that "if we can forestall its installation for a year it will die." Gaining this trust may well require a significant orientation effort that emphasizes the office's positive supportive role to the existent departments.
- The benefits accruing from such a system must outweigh the costs. As cited in an earlier chapter, two institutions claim that their PGM was "worth its weight in gold." We would question whether these statements are based on a careful accounting of the benefits as well as on a real audit of the costs which emphasizes the need for a careful analysis and evaluation.

These demonstration projects should provide working models that will serve as a basis for full-scale implementation of patient grievance systems. No matter what the outcome of these projects, the price for testing these model systems will be far less than that for implementation of a national program.

RECOMMENDATION TWO: A NATIONAL PATIENT GRIEVANCE SYSTEM

Although a minimum of "hard" data as to the need for PGMs yet exists, our research uncovered facts that argue for the establishment of a system. The sentiments voiced at the public hearings held by the Commission, the rising number of lawsuits for malpractice or negligence, and the skepticism the general public is now showing toward health care are indicators of the need for better liaison between health care delivery systems and the health care consumer (or patient). In addition, the findings of this study and those of other SCMM studies strongly indicate that patients need an office whose top priority is their long-term well-being. We assume that the results of the demonstration and testing proposed in Recommendation One confirm this need.

We recommend that all health care institutions, except those rendering only psychiatric services, should be part of a national patient grievance system.

Rationale for this Recommendation

The need for such a national patient grievance system arises out of:

- the isolation and remoteness of many patients. There is the need for an advocate through whom they can communicate their problems and complaints. Close attention given to all patient grievances and early resolution of problems would reduce the number of "nuisance" claims
- the need for the identification of those practices and policies which lead to patient complaints or to malpractice claims
- the need for relieving health care institutions of having to deal with nonmeritorious complaints. The history of ombudsmen systems has shown that 70% to 80% of the complaints filed lack merit. Hence, the introduction of the patient grievance system is likely to demonstrate that for the most part hospitals are well managed and patients well cared for
- the possibility of significantly reducing insurance costs by the reduction of the

number of malpractice claims and amounts involved in settlements of meritorious claims. Similarly, by performing functions such as house counsel, a hospital PGM may result in little or no incremental cost to the institution

- the possibility that consumer/patient concern and activism can be constructively channeled through this system, and lawsuits or other actions currently emanating from patient frustration or remoteness can be diminished or avoided.

Suggested Design of a National Patient Grievance System

Data and information gathered during this study and other non-health care "ombudsmen" experiences indicate that effective consumer grievance resolution comes from many levels of concern depending on the "type" of grievance lodged. Accordingly, to encompass all health care-related grievances we recommend that:

> *DHEW introduce a "tiered" system, consisting of (1) in-hospital PGMs, (2) state level systems, (3) regional DHEW units responsible for technical assistance and monitoring of grievance systems, and (4) a national function of DHEW to act as overseer of the entire system.*

Tier One—The In-Hospital Patient Grievance Mechanism

Within each hospital we recommend establishment of mechanisms similar to those incorporated in the Model Two structure described in Section III.

Objectives—The principal objectives of the Tier I system are:

- to reduce malpractice claims
- to identify and change practices or policies which give rise to malpractice or other complaints, or which detract from the quality of care in other respects
- to provide an empathetic link between patient and institution
- to ensure that patient services are coordinated so that high quality health care is provided.

Coverage of Tier One—As indicated above, the PGM should deal with all types of patient complaints, including malpractice. All areas of hospital service should be included within its jurisdiction, including external extended-care facilities, psychiatric wards, the emergency room and outpatient clinics.

Office Organization—The director of the Tier One PGM should report directly to the institution Administrator and be privileged to bring controversial issues to the attention of the board of trustees. He should have experience in hospital administration, supplemented by a legal or insurance background.

Responsibilities of the PGM would include the volunteer services department, the social services department, and insurance company liaison. Depending on the background of the individual, the office should assume the responsibility of house legal counsel. Although financed and controlled by the hospital administrator and ultimately by the board of directors, the PGM should be given license to cross organizational lines to investigate complaints.

It would be necessary to recruit the type of individual to head such a PGM in a health care institution. There would also be the need for additional staff in the larger institutions (i.e., those over 750 beds) if the unit is to do its job. However, through an extensive use of the volunteer and the social services departments, and through close coordination with the nursing department and individual physicians, added staff requirements could be minimized.

Patient Communication Processes—Each patient should be given, upon entering the hospital, a pamphlet describing his or her rights while in the institution. Such rights would include the right to be informed of all action taken with respect to their care, the right to be treated respectfully by staff, the right to have the facts as to their care kept confidential, and the right to a considerate hearing of their complaint if they believe these rights are abridged. The pamphlet should also contain complaint forms for the patient's use and describe the process through which he may air his complaints.

All hospital staff should be conversant with the pamphlet and complaint filing procedure. If a patient makes a complaint to a staff member which can not be individually taken care of by that individual, the complaint should either be forwarded to the PGM or the patient should be advised of the procedure to follow in presenting his complaint.

Complaint Resolution Process—Complaints handled by the PGM will generally have one of two outcomes: (1) the complaint is found to be lacking in merit, the patient is so advised and the case terminated, or (2) the complaint is found to have merit, and the PGM director must then attempt to remedy the situation.

In either event, the PGM director's first task upon receiving the complaint is to collect all relevant data that will permit a determination as to whether the complaint is justified. These fact-finding procedures will include discussions with the patient and staff members, and the examination of medical records (which must be completely available to the PGM), as appropriate. In instances of malpractice, a committee of physicians should be convened to review the case and determine whether, in their view, malpractice occurred.

The following paragraphs outline approaches for resolving minor service complaints, billing disagreements and malpractice claims.

- If a complaint that does not allege malpractice is found to have merit, the Tier One PGM should utilize the supervisory chain to resolve the problem. For example, if a patient complains that a nurse was rude, the matter should be taken to the Nursing

Supervisor. If the head nurse fails to take the appropriate corrective action, the matter should be referred to the next supervisory level, and before referring a matter to the Administrator, a staff committee should be convened to hear the matter and recommend action. In all instances of disciplinary action, grievance machinery must be available to the employee.

- When hospital billings are the subject of a meritorious complaint, the PGM should have authority to reduce or write off charges. Also, the PGM director should review and comment on all billings to persons who have filed complaints or who were subjects of an incident report. This arrangement will serve as a "double check" to ensure against claims resulting from anger over large or incorrect charges.
- For malpractice claims, the PGM should have authority to write off bills and pay damages up to $25,000. If an equitable settlement of the claim would exceed that amount or the patient insists on more, the PGM should refer the patient to the ABA's lawyer referral service. The PGM should also refer the patient to this service if the patient could be expected to require further medical care or experience continued pain or discomfort. The rationale for this step is to prevent a person from being "bought off" by a fairly large cash settlement that will revert to the institution in payment for the additional care. The PGM should not be a "quick settlement artist," but should make settlement only after investigation of claims and review settlement options with institution management.

PGM Reporting Processes—The PGM should file reports with the administrator not less often than quarterly. When malpractice claims are instituted the Administrator should be informed immediately. In other areas, when deficiencies become apparent, the Administrator should be informed after the evidence has been collected, the facts documented and recommendations formulated. Through such analyses, documentation and recommendations, the patient complaint function performs its real role—that of correcting problems within the overall health care delivery system of the institution or program.

Copies of findings on individual grievances and periodic reports as to the functioning of the health care unit or system should also be sent to the state level Tier Two office. Collective analysis of all state health care institutions and programs can then be made, and we would suggest that a precoded form be designed for recording data on complaints. This form should be one of a series of input devices for a comprehensive patient grievance information system that will monitor local health care problems and provide state-wide information for problem analysis. If each institution has set specific objectives, this information system can also provide performance reports and "red flag" those events that diverge significantly from desirable operation procedure.

Other Responsibilities—The director of a Tier One PGM should have other duties if he is to optimize the value of his function to the institution. These would include:

- sitting on a patient care committee
- sitting on the utilization committee
- serving as an ex officio member of the tissue committee
- serving as an ex officio member of the nursing, social service and volunteer committees

His input will be of value to all of these committees, and will add a new dimension to their considerations. The PGM director could also meet annually with the board of directors and summarize the office's operation during the preceding year. Such a meeting would help ensure that the board was sensitive to patients' problems.

Consortial Arrangements for Smaller Hospitals—Smaller hospitals may not be able to afford a PGM. Where this is the case they may well establish cooperative or consortial arrangements with other hospitals in order to take advantage of the services such an office in another hospital could provide. Through such pooling of resources a staff could be made available to handle patient grievances on a professional and economic basis. However, such collaborative arrangements will not appeal to some institution's managements for two foreseeable reasons: (a) some control would be lost, and (b) a well-run hospital might risk loss of reputation if it were associated with a problem-oriented institution.

Tier Two—State Level Patient Grievance System

The basic objectives of the state system would be to observe, to monitor and to evaluate the grievance handling activities in institutions, to provide overall guidance to in-hospital PGMs throughout the state and to participate in resolution of appealed local claims. This state office would focus on standards of health care and consumer (or patient) satisfaction.

Description of the Tier Two System—The system should be created by statute in each individual state, and, insofar as possible, detached from political influence. Therefore, if its director is appointed by the Governor, his term should be for a long period unrelated to that of the Governor and his appointment should be reviewed by the legislature. The system should be well publicized so that the individual patient or ex-patient recognizes that he has a "place to turn to" if he has a complaint about any medical system in his state.

The key to the system is its leadership and its personality. We suggest that the person who heads the system should have a strong background in law and in health care. To obtain the services of such a person a salary comparable to state cabinet officers will be required. Staff should include individuals with background in insurance, hospital administration and consumer affairs.

Functions of the Tier Two System—The state level system would be expected to observe the operations of Tier One PGMs, to devise a system of reporting to analyze the flow of information from local systems, and to report on the performance of state PGMs. In addition, analyses of trends in health care, the resolution of complaints filed directly with the system, and monitoring, evaluating and providing general guidance to in-hospital PGMs would be expected of the Tier Two unit.

Obtaining information about trends will come mainly from complaint forms, and analyses of these data would be disseminated through periodic reports sent to all of the state's health care institutions. These reports should be publicized appropriately to keep the public aware of trends in health care. The system must stimulate cooperation from, and close working relationships with, other state agencies concerned with health care, including state planning bodies, the state health agency, and the state insurance commissioner. Similarly, license and accreditation boards should be encouraged to utilize information obtained by the system to support their evaluative functions.

If the grievance function receives complaints directly from state citizens, it should refer them to the in-hospital PGM for complete investigation and report. It would then be the responsibility of the Tier One system to satisfy the complainants. However, if the documented solutions to the problem are judged inadequate or are not accepted, the state system can investigate further and recommend changes or serve as a mediator to bring about a resolution. If such an investigation concludes there was malpractice, the system can participate in mediation of a settlement or, if necessary, refer the complainant to the ABA lawyer referral service.

The state level office of the recommended four-tier system would be responsible for developing and operating an evaluation system. When a complaint or series of complaints about an in-hospital PGM indicates unsatisfactory performance, the state system should evaluate the situation objectively and recommend appropriate action for the hospital to improve performance.

Tier Three—DHEW Regional Office Patient Complaint Mechanism

The regional office mechanism will perform essentially the same role for the states in the region as each state performs for the local systems. The regional office organization is envisaged to fulfill the roles of monitor, evaluator and provider of technical assistance to the state and in-hospital grievance mechanisms. To perform these roles, the office should receive and examine state reports on a regular basis, and ensure that trends are recorded and information disseminated to all health care agencies in the region. Regional office staff should regularly visit health care institutions and the state offices so that it may have a first-hand understanding of how experienced PGMs operate in varying situations.

Tier Four—DHEW National Office Patient Complaint Mechanism

Typically, in all Federal organizations field office functions are given leadership and support by a responsible unit in the national office. We believe that this should be the practice in the patient complaint or patient grievance function area as well.

The national office staff will be able to monitor and spot complaints, trends, suits and claims on a national basis and will also be able to provide a necessary coordinative role. The head of this staff should be a high-grade individual with a strong health background, and we anticipate that he would require a small but well-trained staff.

The two primary functions of the national office are (a) the monitoring and evaluation of Patient Grievance Mechanisms and (b) the dissemination of information these mechanisms develop. Once criteria are established, it should evaluate and analyze the operations of in-house and state offices. This office should be able to provide important information for the development and delivery of health care services to the general population, and should be able to recommend policy changes and legislative approaches to the Congress and the Executive branch.

Rationale for the Four Tier Approach—In summary, the following arguments support the suggested four-tiered approach:

- The four tiered system broadens the scope of the patient grievance system so that it is not only a critic of medical practices, but can take positive steps to improve the overall quality of care being delivered. The broader scope of this system is more in line with the concept of comprehensive state or regional health planning than simply addressing the wide range of complaints that individual patients may voice.
- The four-tiered system makes early identification of unfavorable trends possible. For instance, the data supplied by one institution may not indicate a particular problem with a piece of equipment, but when pooled with data from other institutions in the state, problems may be surfaced.
- The four-tiered system provides for intergovernmental coordination that is required to make certain all types of patient health care problems are addressed.
- The four-tiered system provides the patient with protection without going to court. The system would determine the merit of the claim relatively quickly and would encourage or discourage lawyers from picking up the case. The function would be able to reduce frivolous claims and increase the resolution opportunities of poor persons unable to afford the costs of the investigation.

- The four-tiered approach enhances the follow-up powers of the offices at the various levels. If the in-hospital system is being monitored by people at the state level, the staff at the local level will probably do a better initial job and will follow through on such corrective actions as are suggested. The ability to do more than simply recommend, particularly where changes to the system or its processes are concerned, is vital for the office to truly justify its existence, and the "Federal presence" will expand the scope of the office's activities and provide the required residual power to cause change.

OMB Clearance No.
85-S-72-012
October, 1972

Exhibit I

QUESTIONNAIRE
PATIENT COMPLAINT FUNCTIONS IN HEALTH CARE INSTITUTIONS

This questionnaire is designed to describe the ways in which your institution deals with patient complaints and should take about thirty minutes to complete. Some institutions have a patient complaint function or office or have designated a specific person to deal with patient complaints. Others do not have such a function formally designated within the institution's structure.

> THE QUESTIONNAIRE IS IN THREE PARTS THAT SHOULD BE COMPLETED AS FOLLOWS:
>
> *Part A (Green) and Part C (White) are to be completed only by health care institutions which have a specific patient complaint function, or have designated a specific person to deal with patient complaints (Patient Representative, Patient Relations Department, Ombudsman, Patient Advocate, etc.)*
>
> *Part B (Pink) and Part C (White) are to be completed by health care institutions which do not have a specific patient complaint function or a designated person to deal with patient complaints.*

There are two types of questions in this questionnaire. One type requests you to make an "X" in a box beside the answer to a question which best describes your institution, its personnel or procedures. The other asks you to write in your answer. In a few questions you are asked to describe procedures you follow. In answering these questions, please tell us as much as you can about how your institution deals with patient complaints.

If there are any other comments you would like to make on the subject of patient complaints or how they are, or should be dealt with, please feel free to write them out and attach them to this questionnaire.

When you have completed the questionnaire, place it in the enclosed envelope addressed to Social Research Services, Inc. which will process the data and drop it in the mail. No postage is necessary.

Thank you for your participation in this study.

PART A. TO BE ANSWERED BY PERSON RESPONSIBLE FOR PATIENT COMPLAINT FUNCTION

Form 801 (1-3)
Card 1 (4)

(IF MORE THAN ONE FUNCTION, PLEASE HAVE PERSON RESPONSIBLE FOR ONE WITH MOST COMPLAINTS COMPLETE THIS QUESTIONNAIRE.)

A-1. Please write in the title of the person in charge of the patient complaint function.

TITLE: ____________________ (5)

A-2. Is there a written job description or statement of purpose for this function? (PLACE AN "X" IN THE BOX FOR YES OR NO.)

1. ☐ YES 2. ☐ NO (6)

IF YES, please attach a copy, if available, to this questionnaire.

A-3. Please write in the number of years that the patient complaint function has been in operation with a specific person in charge.

NUMBER OF YEARS: __________ (7-8)

A-4. Is the patient complaint function funded 100% by the institution? 1. ☐ YES 2. ☐ NO (9)

IF NO, please list the sources of funds outside the institution which currently support the patient complaint function.

____________________ (10)

____

____

A-5a. If the person in charge speaks any language other than English, please write in language or languages spoken. (11)

LANGUAGE(S) SPOKEN: ____________________

A-5b. Is speaking any language in addition to English preferred for this position? 1. ☐ YES 2. ☐ NO (12)

A-6. Please describe the PERSON IN CHARGE of the patient complaint function by placing an "X" in one of the boxes under each of the following characteristics.

a) Age:
1. ☐ Under 30 (13)
2. ☐ 31 to 45
3. ☐ Over 45

b) Race:
1. ☐ White (14)
2. ☐ Black
3. ☐ Other

c) Sex:
1. ☐ Male (15)
2. ☐ Female

d) Highest level of Education:
1. ☐ Below high school graduate
2. ☐ High school graduate
3. ☐ Some training beyond high school
4. ☐ Associate degree
5. ☐ Nursing diploma
6. ☐ Bachelors degree (including nursing)
7. ☐ Masters degree (16)
8. ☐ Other degree (WRITE IN: ____________________)

e) Study area of highest level of Education:
1. ☐ Nursing
2. ☐ Medical doctor
3. ☐ Other medicine
4. ☐ Law
5. ☐ Social work
6. ☐ Business
7. ☐ Liberal arts 17)
8. ☐ Public health
9. ☐ Other than above (PLEASE LIST ON BACK OF PAGE)

A-7. What is the PRIOR WORK EXPERIENCE of the person in charge of the patient complaint function? Place an "X" opposite all appropriate answers.

1. ☐ Health care administration (18)
2. ☐ Medical doctor (19)
3. ☐ Other medicine (20)
4. ☐ Nursing (21)
5. ☐ Law (22)
6. ☐ Social work (23)
7. ☐ Personnel (24)
8. ☐ Insurance (25)
9. ☐ Office work (26)
10. ☐ (IF OTHER, PLEASE DESCRIBE:) ____________________ (27)

____

A-8. What is salary range of patient complaint function director?

1. ☐ Below $10,000 2. ☐ $10,000 to $14,999 3. ☐ $15,000 to $19,999 4. ☐ $20,000 and over (28)

A-9. To what level of management does this person report? Please write in the management title and place an "X" in the box indicating whether this is the first (highest), second, or third level of management.

MANAGEMENT TITLE: ____________________ (29)

LEVEL OF MANAGEMENT: ☐ FIRST ☐ SECOND ☐ THIRD (30)

A-10. How many staff, including the person in charge, are assigned to the patient complaint function in each of the following categories?

For full-time patient complaint function staff:

A) Number of professional or administrative persons: __________ (31)

B) Number of clerical persons: __________ (32)

For part-time patient complaint function staff:

C) Number of professional or administrative persons: __________ (33)

D) Number of clerical persons: __________ (34)

For volunteers assigned to patient complaint function:

E) Average number of volunteers per day: __________ (35)

A-11. Describe the required qualifications, if any, of all professional staff positions in the patient complaint function. (36)

A-12. How is the director of the patient complaint function selected? Place an "X" beside all methods used.

1. ☐ Personnel office recruiting (37)
2. ☐ Appointment by the chief administrator of the institution (38)
3. ☐ Vote of physicians, nurses or other medical personnel (39)
4. ☐ Selection or appointment by an outside community organization (40)
5. ☐ Vote of patients and former patients (41)
6. ☐ Other methods (PLEASE DESCRIBE:)____________________ (42)

____

A-13. We are interested in finding out:

(a) What procedures are followed in attempting to resolve patient complaints, and
(b) The limits of authority of the patient complaint function.

Please answer the following questions in your own words with this in mind.

1. What are the usual procedures you use to resolve patients complaints?

2. Does the patient complaint function involve higher levels of management in making decisions to resolve patient complaints? If yes, please describe.

3. Are there additional avenues for resolving patient complaints provided or arranged by your institution which are available to the patient or the patient complaint function other than those described above?

4. Does the patient complaint function ever assist a patient in obtaining legal assistance to help him with his complaint against the institution or its staff? If yes, please describe how this is done.

If there is literature describing the procedures for resolving patient complaints, please attach to this questionnaire, if available.

A-14. Place an "X" beside as many appropriate procedures listed below which your patient complaint function follows:

1. ☐ Settles complaints itself (43)
2. ☐ Settles complaints by acting as a go-between between the patient and institution staff (44)
3. ☐ Reviews incident reports and suggests remedial action (45)
4. ☐ Authorizes treatment at no cost to the patient if complaint has merit (46)
5. ☐ Refers complaints with merit to a hearings or advisory board (47)
6. ☐ Advises the patient to seek legal counsel if the complaint is serious (48)
7. ☐ Negotiates with patient's lawyers to resolve complaints (49)
8. ☐ Investigates complaints for insurance carrier (50)
9. ☐ Represents the institution if the complaint goes to arbitration or litigation (51)
10. ☐ Represents the patient if the complaint goes to arbitration or litigation (52)
11. ☐ Acts as a witness for the institution in court suits if requested or subpoenaed (53)
12. ☐ Acts as a witness for the patient in court suits if requested or subpoenaed (54)

A-15a. Which of the following departments, if any, are OUTSIDE the scope of the patient complaint function?

1. ☐ None, function can deal with all institution functions (55)
2. ☐ Outpatient department (56)
3. ☐ Emergency room (57)
4. ☐ Pediatrics (58)
5. ☐ Intensive care (59)
6. ☐ Obstetrics (60)
7. ☐ Psychiatry (61)
8. ☐ Surgery (62)
9. ☐ Medicine (63)
10. ☐ Other (PLEASE LIST BELOW:) ______________ (64)

____

____

A-15b. For each department outside the scope of the patient complaint department, please describe how patient complaints regarding these departments are resolved.

A-16. Please place an "X" beside each type of complaint listed below with which the patient complaint function can deal.

a) Complaints about . . .

1. ☐ Attitudes of nurses (65)
2. ☐ Services of nurses (66)
3. ☐ Attitudes of physicians (67)
4. ☐ Services of physicians (68)
5. ☐ Hospital bills (69)
6. ☐ Insurance or third party payments (70)
7. ☐ Physical injuries due to alleged physician negligence (71)
8. ☐ Physical injuries due to alleged nurse negligence (72)
9. ☐ Housekeeping or maintenance (73)
10. ☐ Physical injuries due to falls (74)
11. ☐ Dietary services (75)
12. ☐ Emergency room delays (76)
13. ☐ Medication misdosages (77)
14. ☐ Admitting procedures (78)
15. ☐ Lost property (79)
16. ☐ Outpatient procedures (80)
17. ☐ Minor patient inconveniences (e.g., bed doesn't elevate, TV set doesn't work) (5)

DUP CARD 1 (1-3)
CARD 2 (4)

b) Write in the three numbers above that represent the most frequent types of complaints received by the patient complaint function?

______ (6-7) ______ (8-9) ______ (10-11)

A-17. Place an "X" beside all applicable sources of patient complaints listed below.

a) Complaints are received from . . .

1. ☐ Patients (12)
2. ☐ Relatives or friends of the patient (13)
3. ☐ The nursing staff (14)
4. ☐ Physicians (15)
5. ☐ The institution administrator or his staff (16)
6. ☐ The business or finance office (17)
7. ☐ Legal department or legal counsel (18)
8. ☐ Other (PLEASE LIST:) ______ (19)

b) Write in the number from above that is the most frequent source of complaints received by the patient complaint function.

______ (20)

c) If complaints are received directly from patients what are the usual methods of communication:

1. ☐ Conversation on the telephone with them (21)
2. ☐ In letters (22)
3. ☐ Questionnaires provided by institution (23)
4. ☐ Conversations during patient representative visits (24)
5. ☐ Other (PLEASE LIST:) ______ (25)

A-18. Does your institution have a written complaint form for patient complaints, or complaints originating from other sources (other than an insurance company incident report)?

1. ☐ YES 2. ☐ NO (26)

IF YES, please attach, if available, to this questionnaire.

A-19. Does your institution have a follow-up questionnaire for use with patients at the time of, or after, discharge from the institution's care?

1. ☐ YES 2. ☐ NO (27)

IF YES, please attach, if available, to this questionnaire.

A-20. a) For what kinds of injuries or incidents can payment be waived by the patient complaint function

a) List the titles of the other institution executives who are involved in these decisions

1. ☐ Falls (general liability) .... 1. ______ (28)

2. ☐ Medication .... 2. ______ (29)

3. ☐ Hospital bills .... 3. ______________________________ (30)

____

4. ☐ Malpractice .... 4. ______________________________ (31)

____

5. ☐ Other (LIST BELOW:) .... 5. ______________________________ (32)

______________________________ ______________________________

______________________________ ______________________________

b) Does the patient complaint function waive payment for remedial treatment related to an incident without approval of other executives in the institution?

1. ☐ YES 2. ☐ NO (33)

IF YES, write in the amount of the financial limits of this authority.

$______________________________ (34-38)

A-21a. Describe briefly the process your institution uses to deal with claims alleging medical malpractice:

A-21b. In what ways does the patient complaint function participate in resolving malpractice claims?

PLEASE COMPLETE PART C OF THE QUESTIONNAIRE.

PART B. TO BE COMPLETED BY HEALTH CARE INSTITUTIONS WHICH DO NOT HAVE A SPECIFIC PATIENT COMPLAINT FUNCTION OR DESIGNATED PERSON TO RESOLVE PATIENT COMPLAINTS.

B-1. In the absence of a specific function or designated person, please describe as fully as possible how the following types of patient complaints are dealth with in your institution.

a) "Contact" (staff service, attitudes, housekeeping, etc.) complaints:

b) Financial complaints:

c) Complaints alleging malpractice:

d) Other complaints

B-2. Has your institution had a formal patient complaint function that has been discontinued?

1. ☐ YES 2. ☐ NO (39)

IF YES, why was it discontinued?

PLEASE COMPLETE PART C OF THE QUESTIONNAIRE.

PART C. INSTITUTIONAL DATA

C-1. If there is more than one patient complaint function in this institution, please list other titles and areas covered.

1. Title ________________ Coverage ________________ (40)
2. Title ________________ Coverage ________________
3. Title ________________ Coverage ________________

C-2. Type of institution (CHECK ONE ANSWER) (41)

1. ☐ Hospital (teaching)
2. ☐ Hospital (non-teaching)
3. ☐ OEO organized neighborhood health center
4. ☐ Clinic
5. ☐ Health maintenance organization
6. ☐ Nursing home
7. ☐ Other (PLEASE DESCRIBE:) ________________

____

____

C-3. Type of control (CHECK ONE ANSWER)

Government, non-Federal (42)

1. ☐ State
2. ☐ County
3. ☐ City
4. ☐ City-County
5. ☐ District

Government, Federal (43)

1. ☐ Armed forces
2. ☐ Public health service
3. ☐ Veterans administration
4. ☐ Other

Non-Governmental, not for profit (44)

1. ☐ Church operated
2. ☐ Other operated

For profit (45)

1. ☐ Individual
2. ☐ Partnership
3. ☐ Corporation

C-4. If a hospital, estimate percent of patients treated for less than 30 days (CHECK ONE ANSWER) (46)

1. ☐ 25% or less
2. ☐ 26% to 50%
3. ☐ 51% to 75%
4. ☐ 76% to 100%

C-5. Number of beds (CHECK ONE ANSWER) (47)

1. ☐ None
2. ☐ From 1 to 199
3. ☐ From 200 to 299
4. ☐ From 300 to 399
5. ☐ From 400 to 499
6. ☐ From 500 to 749
7. ☐ From 750 to 999
8. ☐ 1,000 or more

C-6. Estimate number of admissions over a 12 month period (CHECK ONE ANSWER) (48)

1. ☐ None
2. ☐ Under 5,000
3. ☐ 5,000 to 9,999
4. ☐ 10,000 to 14,999
5. ☐ 15,000 to 19,999
6. ☐ 20,000 to 24,999
7. ☐ 25,000 to 29,999
8. ☐ 30,000 or more

C-7. The following questions refer to your patients. Please place an "X" under the percent which best approximates your patient population. (IF EXACT STATISTICS ARE NOT AVAILABLE, PLEASE ESTIMATE.)

WHAT PERCENT OF YOUR PATIENTS ARE . . .	20% Or Less −1	21% To 40% −2	41% To 60% −3	61% To 80% −4	81% To 100% −5	
1. Males	☐	☐	☐	☐	☐	(49)
2. Between 0 and 17 years of age	☐	☐	☐	☐	☐	(50)
3. Between 18 and 40 years of age	☐	☐	☐	☐	☐	(51)
4. Between 41 and 60 years of age	☐	☐	☐	☐	☐	(52)
5. Over 60 years of age	☐	☐	☐	☐	☐	(53)
6. White race	☐	☐	☐	☐	☐	(54)
7. Black race	☐	☐	☐	☐	☐	(55)
8. Other race	☐	☐	☐	☐	☐	(56)
9. Earning annual incomes under $6,000	☐	☐	☐	☐	☐	(57)
10. Earning annual incomes of $6,000 to $14,999	☐	☐	☐	☐	☐	(58)
11. Earning annual incomes of $15,000 & over	☐	☐	☐	☐	☐	(59)
12. Spanish speaking	☐	☐	☐	☐	☐	(60)
13. Other foreign language speaking	☐	☐	☐	☐	☐	(61)
14. Medicare/Medicaid insured	☐	☐	☐	☐	☐	(62)
15. Privately insured	☐	☐	☐	☐	☐	(63)
16. Not insured	☐	☐	☐	☐	☐	(64)

C-8. The one type of service which best describes the services provided to the majority of patients.

1. ☐ General medical and/or surgical (65)
2. ☐ Psychiatric
3. ☐ Tuberculosis and other respiratory diseases
4. ☐ Geriatric
5. ☐ Eye, ear, nose and throat
6. ☐ Rehabilitation
7. ☐ Orthopedic
8. ☐ Chronic disease
9. ☐ Obstetrics/Gynecology
10. ☐ Other (PLEASE DESCRIBE:) ______________________________

____

C-9. What is the amount deductible of your malpractice and general liability insurance policy?

$ ____________________ (66-71)

C-10. In your frank opinion, how would you rate the procedure(s) used to resolve patient complaints in your institution.

1. ☐ Excellent (72)
2. ☐ Good
3. ☐ Average
4. ☐ Fair
5. ☐ Poor

(73-76)

NAME AND ADDRESS OF INSTITUTION AND YOUR TITLE

NAME ______________________________

ADDRESS ______________________________

CITY ____________________ STATE __________

YOUR TITLE ______________________________

Exhibit II

INTERVIEW GUIDE

Institution ______________________

____

Date: ______________________

Respondent Name ______________________

____

Title: ______________________

____

1. Description of patient complaint system (from respondent's point of view):

   – What is the mission?
   – What "types" of complaints does it deal with?
   – Why and when was it created (specific incidents)?
   – What is its scope (Coverage within institution)?
   – What other avenues do patients have to lodge complaints (medical societies, etc.)?
   – Whose side is the PGM on?

2. What position does the PGM have in the institution organization?

   – Actual working and formal relationships between PGM and:
     - administration
     - doctors
     - nurses
     - insurance
     - finance
     - legal

   – Limits of authority (can PGM cross organizational lines)?
   – Give examples of interface between your function and the PGM.

3. Describe the complaint resolution process with respect to your function.

   – Who (what office) usually receives patient complaints?
   – What is the usual first step for resolution?
   – What is the extent of PGM involvement?
   – What reporting system is in place for reporting complaints?
   – Cite some specific examples of complaints involving your function.

4. What is the usual process for dealing with complaints alleging malpractice?

   – Point of intervention of insurance carriers and legal staff.
   – Role of PGM in dealing with such complaints (cite examples).
   – Does the PGM ever try to *settle* claims (cite examples)?
   – What problems are inherent in this process?

ATTITUDINAL RESPONSES

1. Do you think the PGM is accomplishing what it was designed to do?

   – If not, why not (highlight problem areas)?
   – Has it accomplished more than it was designed to do? If yes, describe.

2. Do you think the PGM has reduced the level of general patient dissatisfaction since its inception? (Cite reasons why or why not.)

   – If not, what changes in the present complaint resolution system would you recommend?

3a. Do you think the PGM has had any effect on the level of malpractice suits filed against the institution? (Cite examples.)

3b. Do you think the PGM should act as a go-between between the patient and the institution for complaints of alleged malpractice? If so, describe.

4. In your opinion, is the PGM a welcome function in the institution? Cite examples of acceptance.

   – If not, why not? (Who/what functions do not accept?)

PATIENT INTERVIEW GUIDE

Name:________________ Interviewer: ________________

Institution: ________________ Date: ________________

Patient Experience with Patient Grievance Mechanism

1. How did you become involved with the PGM?
2. How did you know about the PGM?
3. What was the complaint?
4. What did the PGM do in response to your complaint?
5. What was the result of the PGM's action?

Patient Satisfaction with PGM

1. How satisfied are you with the PGM?
2. If not satisfied, what alternative action(s) did, or would, you like to have taken?
3. How aware are you of the professional qualifications and organizational relationships of PGM? Did this have a bearing on your attitude toward PGM?
4. Other observations:

PATIENT REPRESENTATIVE/OMBUDSMAN INTERVIEW GUIDE

Name:________________ Interviewer: ________________

Title: ________________ Date:________________

Institution:________________

1. What is the purpose of the office? (Obtain job description or mission statement, if available.)
2. Please tell us the history of the office and any problems experienced in setting it up.
3. How much time do you spend on PSR? If not 100%, what do you do with the rest?
4. Please describe the system.

   – Communication linkages with patient

   – Hospital areas PSR covers, and why he doesn't cover all areas.
   How are grievances in those areas handled?

- Types of complaints (e.g., malpractice) *not* handled and what grievance process is for such types.
- Patient complaint resolution process
- PSR response process
- Way patients dealt with when grievance found nonmeritorious
- PSR approach if complaint has merit
- Financing of PSR
- Do you deal with incident reports? In what manner?
- Break down tine spent by type of complaint
- Estimated caseload

5. In general, is your system appreciated by other hospital personnel?
6. In your opinion, is your system achieving the results expected when it was started?
7. (If PSR does not deal with malpractice) Could office deal with malpractice?
8. How could office be made to function better?
9. What *should* qualifications of PSR be?
10. Describe what the ideal PGM "model" would be from your point of view.

Exhibit III

MODEL #1

BASIC LEVEL PATIENT GRIEVANCE MECHANISM

Assumed Objectives:	Serve as a buffer between administration and patients complaining about minor operating deficiencies and assist in their resolution
System Elements and Operations:	• *Types of complaints handled:* food; housekeeping; staff attitude toward patients; discussion of case in presence of third parties; flexible visiting hours for "hardship" cases; scheduling of clinical appointments. • *Areas covered:* Comprehensive institutional coverage except for psychiatric and extended-care facilities (ECFs) • *Information on function to patients:* booklet describing process presented at admission; phone number displayed prominently in each room • *Notification process:* scheduled ward visits; telephone with "beeper" system; staff complaints about patients; office visits from patients (office easily accessible), family visitors; from administrator if formal system bypassed; post-stay questionnaire • *Fact-finding and solution process:* investigate substance of complaint; determine merit; report justified complaints to supervisor (head nurse, chief of medicine, ED head); explain to patient why claim was found to be unjustified or cannot be corrected • *Financed* at cost not to exceed $25,000 annually • *Organizational relationship:* report to assistant or associate administrator

- *Authority:* recommend reassignment or termination of personnel; recommend systematic change (convenience foods, contract maintenance, etc.) correct billing errors
- *Staffing pattern:* three people: one as head of group at approximately $8,500, with college degree and some hospital experience; one to work with inpatients, with "airline hostess" background at approximately $6,500; one full-time in the emergency department from community at approximately $6,500. All should be female and the person in the emergency department should come from surrounding community. Clerical provided by volunteers
- *Selection process:* office director chosen by the administrator with advice from community on emergency department representative; other staff selected by normal personnel process
- *Miscellaneous functions:* head of PGM should sit on Patient Care Committee; assist in placing postoperative patients in extended-care facility (ECF); take care of VIPs

Likely Cost: Not to exceed $25,000 annually

Anticipated Benefits:

- Reduce demands on top administrators' time by eliminating nonmeritorious and minor complaints from their purview
- Serve as clearinghouse for minor complaints
- Overcome patients' feeling of isolation from staff to some degree
- Improve patient flow by better scheduling
- Improve utilization by getting patients to ECFs more rapidly upon physician's approval
- Help staff deal with "difficult" patients by serving as liaison
- Inject patient dissatisfactions into policy level discussions of patient care
- Indicate a willingness for the institution to try to meet the community's needs

Key Factors for Success:

- Personality and empathy of PGM staff
- Acceptance of function by "institutional professionals"
- Use of advice gathered on ward visits and from questionnaire by higher authorities to implement indicated systemic change
- Ability to gather factual data to make "fair" decisions on the merits of complaints

Exhibit IV

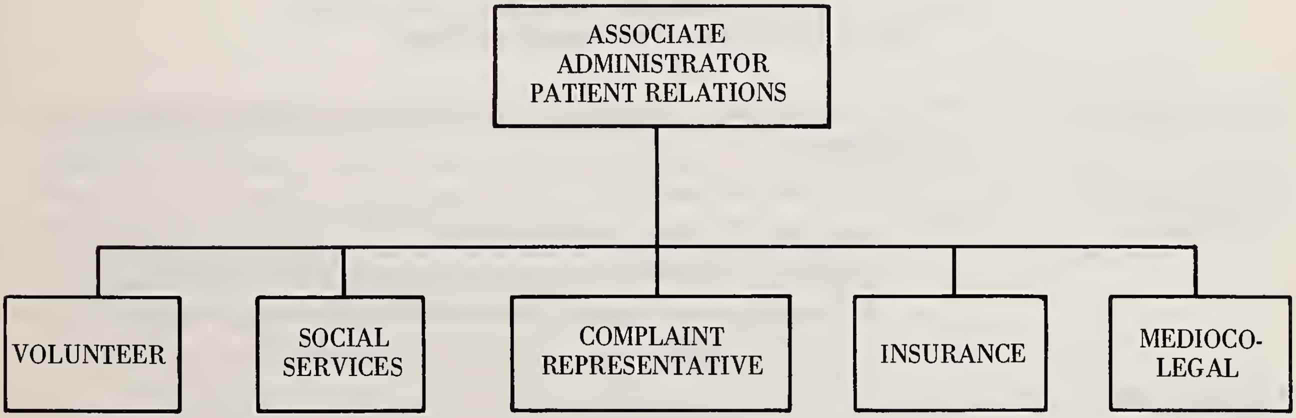
MODEL #2
COMPREHENSIVE INTERNAL PATIENT GRIEVANCE MECHANISM

Assumed Objectives: By addressing *all* patient complaints:

- Reduce malpractice suits, settlements, and free care allocations resulting from institutional negligence
- Conduct analyses to introduce needed systemic changes
- Improve utilization rate by facilitating patient flow
- Overcome patients' feelings of "isolation" by serving as an empathetic link between the professional staff and the patient
- Reduce malpractice insurance premiums

System Elements
and Operations:

- *Types of complaints handled:* All complaints *including* physician malpractice
- *Areas covered:* All areas served by institution
- *Codification:* Booklet given patient at admission enumerating patient rights, e.g., acceptable level of care, confidentiality, informed consent
    - describes notification process
    - describes grievance resolution and appeals process
- *Notification process:* Standard complaint form; incident report, scheduled ward visits; telephone and "beeper" system; outstationed complaint information center; legal correspondence via administrator; staff intermediary complaints about specific patients
- *Fact-finding and solution process:* investigate substance of complaint: in malpractice situations, assemble ad hoc medical committee to determine merit; in all other cases determine merit of complaint by investigation and utilize supervisory chain (head nurse, chief of medical service, dietician, etc.) to make necessary adjustments. Should adjustments not satisfy the patient or the patient grievance mechanism a board of staff, board members and outside community should be assembled to recommend action to the administrator. In actions involving personnel termination or discipline the process should be integrated into the employee grievance process. In situations where the complaint is found to be nonmeritorious the staff shall explain to the patient the results of the investigation and the conclusions. If it is obvious that an amicable settlement of the patient's grievance cannot be reached, the office should refer the patient to a lawyer.
- *Organization* should be financed and controlled by hospital but institutionalized in bylaws
- *The Head* of the patient grievance mechanism should be at the assistant or associate administrator rank and should report directly to the administrator. The office should have line jurisdiction over the following departments:
    - social services
    - institutional insurance
    - volunteer services
    - medico-legal/in-house counsel
    - basic level patient complaint representatives



- *Authority:* The ability to require attendance at ad hoc meetings; the ability to "write-off" bills for billing errors and as compensation for damages. Payments for damages below the deductible limit (except where continued medical care resulting from iatrogenic injury is required, where pain and suffering persists, or where damage verdicts normally exceed $25,000) will be made on the office's sole authority.
- *Staffing pattern:* The pattern should be along functional line with:
    - individuals in the $6,500 bracket with an "airline hostess' background for ward visits and model #1 type duties; registered nurses should staff the intensive care and ED at approximately $10,000-$12,000 annually. The social service and volunteer departments should be staffed as normal, with the insurance representation constant with current patterns. The head of the office should have a legal or strong top level hospital administrative background.
- *Miscellaneous functions:* The director of the PGM should sit on both the utilization and patient care committees. Staff members would provide assistance in locating ECFs and in transferring people to other health care institutions. On occasion the PGM might serve the public relations role of escorting VIPs. The importance of the final function of investigating operating problems cannot be overemphasized because good recommendations can reduce accidents and more nearly satisfy the psychological needs of the patients. If the office head is a qualified attorney he could serve as house counsel.
- Costs dependent on staff and hospital size

Anticipated Benefits:

- Overall increased patient satisfaction as reflected in post-stay questionnaires and fund-raising contributions
- Better utilization of available beds
- Reduction of accidents related to operational problems (bad lighting, improper equipment)
- Reduction of malpractice cases
- Insurance premium reductions

Exhibit V

MODEL #3

LEGISLATIVELY BASED OMBUDSMAN DEALING EXCLUSIVELY WITH MALPRACTICE

Assumed Objectives:

To resolve malpractice claims and to cause changes in the system that improve health care delivery

Systems Elements and Operations:

- *Areas covered:* all health care institutions
- *Codification:* booklet describing patient rights provided each patient
- *Notification process:* state-wide standard precoded for computer number for state ombudsman's office

Fact-Finding and Solution Process:

Conduct in-depth fact-finding with access to all records and subpoena power over involved parties. Through arrangements with state medical societies obtain expert in discipline who would conduct impartial examinations. These individuals would not come from the hospital being investigated. Serves as decision agency in court if settlement not forthcoming. If case has merit assist in obtaining counsel as required. If no merit inform the affected parties that there is no perceived merit

Totally independent, created by statute as the state ombudsmen are in Ohio and Hawaii

Authority: consists of recommending payment of damages, cancellation of bills and changes in systemic operations

Staffing pattern: headed by a man with the respect of all medical care institutions at a salary of at least $40,000 per year. Should have a background in law and medicine and be supported by staff with legal, medical, insurance, hospital administrative background, at the rate of one assistant for every 1,000 beds. The person should be selected by the chief elected official and should serve a term that ensures continuance if there is a change in administrations. The assistants should go through the state civil service process.

Potential Benefits:

- reduction of malpractice suits
- reduction of frivolous claims
- improved overall health care
- reduction of insurance premiums

Key Factors of Success:

- credibility of individual heading office
- knowledge of an acceptance of role by
    - state officials and control agencies
    - lawyers
    - plaintiffs/patients
    - hospital administrators
    - insurance companies
- ability to obtain records and interview affected parties
- ability to handle the increasing volume of complaints that may be filed
- effectiveness of management information system to identify problematic health care trends

Exhibit VI

INSTRUCTION SHEET
KEY FACTOR SYSTEM DEVELOPMENT

The following sheets depict the Key Factors in Patient Grievance Mechanisms that we have identified following a nationwide survey of such systems. We have presented several sample systems that we conceptualized for your comments and criticisms, but we would now like to go through the Key Factor sheets to delineate the system best suited for your institution. We recognized early in our study that each institution has unique qualities and that the administrator and his staff will have individual objectives for a mechanism to confront patient grievances. As a result of this awareness, we want to work with you to create the system you feel best suited for your institution.

In order to construct these systems, we need:

1. a brief description of the institutional or organizational environment
2. the goals and objectives you would have for such a system
3. a careful weighing of the factors we have delineated that comprise a Patient Grievance Mechanism. This process consists of:
    a. *checking the boxes of those factors you feel to be necessary*

   b. *rating (on an ascending scale from 1 to 10) the importance you attach to the components you have designated as important*
   c. *describing to us why these items are important in the system you are developing during our meeting*
4. an estimate of the cost of establishing such a system and a statement of the cost ceiling
5. a description of the specific benefits such a system might yield and what causal relationships exist
6. a description of the key factors for success and roadblocks that must be overcome, with a description of strategies for overcoming them.

The product of this effort will be a set of Patient Grievance Mechanisms designed to meet the needs of various health care installations with a careful analysis to describe the essential system elements. The "model" systems will form the backbone of our report to the Commission on Medical Malpractice and their importance cannot be overemphasized.

Examples

1. If you feel the most important area of the hospital to be included in the Patient Grievance Mechanism's jurisdiction is the *inpatient* department, your response would be, under Areas of the Hospital Covered (B):

   [✓] 10 1. inpatient

2. If you feel the *emergency department* is important but significantly less so your response might be:

   [✓] 6 5. emergency department

3. If you feel outpatient coverage would be helpful but is not crucial your response might be:

   [✓] 1 2. outpatient

KEY FACTORS IN PATIENT GRIEVANCE MECHANISMS

A. Type of Complaint

[ ] ______ 1. food
[ ] ______ 2. housekeeping
[ ] ______ 3. staff attitude
[ ] ______ 4. discussion of case
[ ] ______ 5. visiting hours
[ ] ______ 6. scheduling
[ ] ______ 7. falls
[ ] ______ 8. medication errors
[ ] ______ 9. choice of doctor
[ ] ______ 10. refusal of treatment
[ ] ______ 11. right to leave or stay
[ ] ______ 12. failure of therapeutic care
[ ] ______ 13. exemption from experiment
[ ] ______ 14. confidentiality
[ ] ______ 15. lost items
[ ] ______ 16. physician negligence/malpractice
[ ] ______ 17. informed consent
[ ] ______ 18. general liability
[ ] ______ 19. nursing/staff negligence

B. Areas of Hospital Covered

[ ]______1. inpatient
[ ]______2. outpatient
[ ]______3. pediatrics
[ ]______4. psychiatric
[ ]______5. emergency department
[ ]______6. special related institution/nursing home

C. Codification

[ ]______1. patient rights
[ ]______2. booklet describing process
[ ]______3. phone number publicized

D. Notification Process

[ ]______1. pamphlet/distribution
[ ]______2. complaint form
[ ]______3. scheduled ward visits
[ ]______4. telephone
[ ]______5. staff intermediary
(nurse, social worker)
[ ]______6. incident report/patient award
[ ]______7. visit office (complaint hours)
[ ]______8. family/visitors
[ ]______9. administrator
[ ]______10. questionnaire

E. Fact-Finding and Solution Process

[ ]______1. fact-finding
[ ]______2. records available
[ ]______3. personnel available on request
[ ]______4. discussion with offending party
[ ]______5. report action through supervisory claim
[ ]______6. go to hearings board
[ ]______7. composition of hearings board
    [ ]______a. consumers
    [ ]______b. board of directors
    [ ]______c. staff
    [ ]______d. outside mediators
    [ ]______e. outside arbitrators
    [ ]______f. local medical society grievance committee
    [ ]______ad hoc
    [ ]______standing
[ ]______8. refer to lawyer
[ ]______9. report findings to regulatory agency
[ ]______10. publicize findings

F. Completely Hospital Financed and Controlled

G. Independent Organization

- [ ] ______ 1. medical society
- [ ] ______ 2. community group
- [ ] ______ 3. contract with external agency
- [ ] ______ 4. legislatively based

H. Organizational Relationships—Report to

- [ ] ______ 1. first level (administrator)
- [ ] ______ 2. second level (assistant of associate administrator)
- [ ] ______ 3. third level (head of service)
- [ ] ______ 4. lower
- [ ] ______ 5. special committee
- [ ] ______ 6. separate medico-legal office

I. Authority

- [ ] ______ 1. write off bills
    - [ ] ______ a. billing errors
    - [ ] ______ b. compensatory/patient knowledge
    - [ ] ______ c. compensatory/without knowledge
- [ ] ______ 2. pay damages
    - [ ] ______ a. actual
    - [ ] ______ b. pain and suffering
- [ ] ______ 3. require staff attendance at joint meeting
- [ ] ______ 4. recommend termination of personnel
- [ ] ______ 5. recommend systemic change

J. Staffing Pattern

- [ ] ______ 1. salary
    - [ ] ______ a. $10,000 or less
    - [ ] ______ b. $10,000 to $15,000
    - [ ] ______ c. $15,001 or more
- [ ] ______ 2. tenure
    - [ ] ______ a. fewer than 5 years
    - [ ] ______ b. 5 to 10 years
    - [ ] ______ c. more than 10 years
- [ ] ______ 3. background
    - [ ] ______ a. social worker
    - [ ] ______ b. doctor
    - [ ] ______ c. lawyer
    - [ ] ______ d. nurse
    - [ ] ______ e. administrator
    - [ ] ______ f. community member
    - [ ] ______ g. college educated, generalist
    - [ ] ______ h. insurance agent trained
    - [ ] ______ i. does not matter
- [ ] ______ 4. sex
    - [ ] ______ a. male
    - [ ] ______ b. female

[ ]______5. race
  [ ]______a. black
  [ ]______b. white
  [ ]______c. other
[ ]______6. ethnic

K. Selection process – by
[ ]______1. administrator
[ ]______2. community group
[ ]______3. board of directors
[ ]______4. special hospital panel
[ ]______5. normal personnel process

L. Miscellaneous Functions
[ ]______1. committee memberships
  [ ]______a. utilization
  [ ]______b. patient care
  [ ]______c. other
[ ]______2. third party payment assistance
  [ ]______a. represent patient at a fair hearing
[ ]______3. locate nursing home
[ ]______4. notify next of kin of death
[ ]______5. take care of VIPs
[ ]______6. arrange for hospital transfer
[ ]______7. conduct systemic studies
  [ ]______a. falls
  [ ]______b. equipment
  [ ]______c. other

M. Discussion of Roadblocks

1. hospital staff opposition
2. medical society opposition.
3. financing
4. duplication
5. utility
6. insurance company
7. hospital unions

"NO-FAULT" COMPENSATION FOR PERSONAL INJURY IN NEW ZEALAND

Arthur H. Bernstein

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Resolving medical malpractice controversies is an American problem. Nowhere else in the world—not even in neighboring Canada[1] or in prosperous Western democracies—is this a serious concern. In other countries sharing our Anglo-Saxon legal antecedents it is difficult to convince knowledgeable persons that the incidence of malpractice litigation in the United States really is what it is. In those nations the malpractice problem was not solved; it simply never arose. Yet, in distant New Zealand, where there is no detectable malpractice problem either, there are revolutionary developments that could help to lead the way towards a solution to our predicament, or save us from errors as we change our system.

The government of New Zealand is embarking upon an experiment of considerable potential for all industrialized nations. It is proceeding to implement much of the program suggested by a Royal Commission, after copious discussion by deliberative groups both in and out of government, to resolve the social, economic, and health problems arising from accidental injuries.[2] A basic objective is to eliminate tort litigation. In most cases, fault or negligence would be irrelevant and the happening of a prescribed event, such as an accident arising out of use of an automobile, industrial injury, or a household accident, would lead to suitable medical treatment and financial compensation for the victim.

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[1] Lavin, J.H., "Should We Import Canadian-Style Malpractice Defense"? *Medical Economics*, Jan. 17, 1972, p. 140.

[2] For a detailed history and commentary by an informed insider, current as of Spring 1971, see Palmer, G.W.R., "Abolishing the Personal Injury Tort System: The New Zealand Experience," 9 *Alberta Law Review* 169, June, 1971.

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For Americans seeking possible relief from the ills of our method of handling malpractice claims, there is much pertinence in the New Zealand plan. Many malpractice incidents are "accidents" and would be so considered under the no-fault system, even though mere sickness or disease would be excluded. However, the "gray area" between (1) accident or preventable therapeutic misadventure, and (2) illness, or noncompensable complications of therapy, remains to be defined. Whether it can be clarified may well determine if any benefits can be gained from New Zealand by Americans in their quest for a more simple, quick, inexpensive, and fair method for resolving claims predicated upon medical malpractice. Any period of meaningful experience under the proposed New Zealand arrangement, unfortunately, will take a few years. Perhaps impatient America cannot wait and will risk its own experimental solution to the malpractice problem before the New Zealand results are available.

Why New Zealand? For what reason is this uncomplicated, peaceful corner of the world a potential guide for the turbulent and complex United States? The answer will develop presently. But, because it is so little known, first we had best describe the country and its institutions. We will next examine its health care system and tort ligitagion methods, then conclude on the recent developments towards the no-fault standard for settling personal injury problems, including many medical malpractice claims.

ABOUT NEW ZEALAND

Tucked away in the South Pacific, some 7000 miles from our West Coast, New Zealand is a handsome and sometimes paradoxical land. It is almost as green as Ireland, as alpine as Switzerland, and as orderly as Great Britain. In size it is about the same as Colorado. Its climate is truly temperate. No part of the country is more than seventy miles from a coast and everyone lives no more than an hour's flight from the capital. Neighboring Australia is about three hours away by jet.[3]

Despite its well developed and efficient agricultural industry, New Zealand can be considered an urban nation. Some 60% of the citizenry reside in cities, with the four largest housing 40% of the total.[4] This is significant to our interests, for those cities are crammed with automobiles. "Panel beaters"—automobile body shops—do a brisk business. Automobile accidents are numerous and the liability insurance—litigation system for determining responsibility is only a little more popular than in the United States. About half the population is engaged in manufacturing and commerce. Hence, the "workers' compensation" program has widespread impact and its deficiencies are a nationwide concern. In these two areas our two countries have parallel problems. It is in the realm of the economics and delivery of health care, and in the remunerating of attorneys in tort litigation, where the New Zealand experience strays farthest from our own. Nevertheless, there remains a surprising similarity among the recognized discrepancies of the health care and litigating systems of the two countries. Because New Zealand appears to be farther along in the cycle of creating and replacing twentieth century social institutions than are most democracies, its current endeavors bear close watching.

There is more that we should know about the land and its people before approaching the no-fault issue. The population is less than 3,000,000, growing slowly and mostly from within, but aided by selective immigration. The indigenous Polynesian people, the Maoris, constitute about 8% of the total. There are also Samoans and others from South Pacific islands under New Zealand administration. The non-whites as a group tend to have the least educational attainment, the undesirable jobs, and the poorest health. An "affirmative action" approach to improving their lot seems to be succeeding. About 90% of the population is of British origin. The literacy rate is virtually 100%. In many respects New Zealand is British, without the overpopulation, historic structures, and intense class distinctions, but with scenery and a considerable egalitarianism. Perhaps it is what Britain could be if it had but three million people, only one century of history, a decent climate, and plenty of home grown food.

Some 12% of New Zealand's work force is engaged in agriculture. Yet, 90% of the country's exports consist of meat, dairy products, farm produce, and wool. Obviously, the farmers and food processors are quite efficient. There is a favorable balance of trade more years than not. Imports are heavily represented by machinery, oil, chemicals, textiles, and motor vehicles.

New Zealand is hardly an example of a free enterprise economy. The government is deeply involved in commerce through ownership of business, imposition of tariffs, import and export controls, taxation, and licensing. Among government operated industries are the rail and airlines, coal mines, telephone, broadcasting, and electricity. The state owns about half the timber resources and either builds or finances half the housing erected each year. Personal income taxes are steeply graduated. Taxable income in excess of $12,000, for example, is assessed at a 67% rate. Hidden sales taxes at the wholesale level add 20% to the cost of many consumer items. For these exactions the New Zealander does obtain a *quid pro quo*. Of the national budget, 43% is for welfare and social services, which we shall examine presently, and only 7% for defense.

Great Britain acquired New Zealand in 1840 by treaty with the Maori tribes. Subsequent colonization was impeded by the natives' hostility until the Maoris were all but decimated in the 1860's—a history not unlike our own. The sheep and cattle were introduced in the 1890's (there were no four-footed mammals on the islands except as introduced by man), stimulating overseas trade and laying the foundation for a social democracy. "Welfare state" attitudes have prevailed throughout this century, during dominion status beginning in 1917 and under autonomous nationhood since 1947.

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[3] Inasmuch as the primary purpose of this paper is not to investigate the geographic, economic, and historical facts about New Zealand, there will be few references given when these areas are discussed. The reader can find ready reference to the desired factual information in encyclopedias and specialized texts.

[4] There is an annual government publication, produced by the Department of Statistics in Wellington, entitled *The New Zealand Official Year Book,* which contains over 1300 pages of information and data concerning trade, population, health, social development, and much more. All the statistics in these categories mentioned herein can be brought up to date by referring to the latest issue.

As a member of the British Commonwealth of Nations, New Zealand recognizes Queen Elizabeth II as sovereign and accepts her representative, the Governor General. A truly independent country, despite its allegiance to Her Majesty, New Zealand has an effective parliamentary system. The Prime Minister is the leader of the party winning a majority of seats in the House of Representatives. This is a unicameral legislature; there is no House of Lords to impede legislation. The Prime Minister is assisted by a cabinet of 16 members of Parliament. In the House there are 84 seats, 4 of which are reserved for Maoris who are separately elected by their constituency. Terms of office are for 3 years. 1972 is an election year and how the government (the party in office) handles the no-fault bill before the November balloting may well influence that vote. The National Party, a conservative (read "moderately liberal" by American standards) group, holds office by a margin of only about 4 seats over the Labour Party, which is dedicated to increased governmental ownership and control of industry and added social welfare benefits.[5] The Communists and Social Credit adherents add variety to the legislature but no power or influence.

It is said the difference between the National and Labour parties is that the former is in office. Although theoretically favoring free enterprise, the National Party has not dismantled the welfare mechanisms established by the Labourites when they were in power. In fact, the history of New Zealand politics in the last 40 years has been of Labour introducing broad social and economic reform programs and the National Party condemning certain aspects of the schemes but retaining the programs. Thus, between 1935 and 1949, the Labor government adopted a comprehensive social security program, started large scale public works, and approved a minimum wage law. The Reserve Bank and Mortgage Corporation were nationalized and union membership and recognition greatly favored by government action. In office previously from 1949-1957, the National Party proceeded cautiously, modifying some import restrictions and price controls. In its present term, running from 1960, compulsory unionism has been eased but the mixed economy of government and private ventures is continuing, and the social welfare concepts remain as accepted principles.

THE LAW, LAWYERS, AND COURTS

Like Great Britain, New Zealand lacks a written constitution and manages very nicely without one. Dedication to civil rights and civil liberties is traditional. It would be hard to find a people anywhere on earth more sincerely devoted to due process and equal protection of the laws. This may be more readily accomplished in a society when few are poor or uneducated, very few are rich, and all maintain a decent standard of living, assisted by the government in obtaining what the electorate considers to be the necessities of life.

The judicial system of New Zealand is strongly influenced by the British, but as is true of other organizational patterns, the British judicial structure has been simplified. Justice is relatively rapid, too. Magistrates' courts have jurisdiction over minor criminal matters and civil claims up to $2000. There are no juries at this level and a case rarely takes more than a few months from commencement to conclusion. The Supreme Court is the court of general jurisdiction, handling civil and criminal cases, including probate, divorce, and admiralty. Jury trials are permitted and the time from "issuance of a writ" to the hearing in a civil case runs about six months to a year. Appeal is to the Court of Appeal, made up of four Supreme Court judges. It is possible to obtain further judicial review outside the country by the Judicial Committee of English Privy Council, so intertwined with the British legal system is the New Zealand legal process.

The legal profession is an honorable one in New Zealand. Perhaps this is due to the integrity of the practicioners, or maybe it is a reflection of the general decorum of New Zealanders. Some would suggest that the absence of contingent fees is a contributing factor. At least a number of leading members of the New Zealand bar think so.[6] The thought of compensating an attorney on a commission basis, without regard to the work he has done for his client, is abhorrent to New Zealand barristers and solicitors. They consider it thoroughly unjustifiable, in fact, unethical. Then how are they paid for handling tort claims? They are paid for the work actually performed, generally as approved by the court. Usually an hourly rate is applied. In this way the lawyers manage to earn a respectable living, deriving compensation for their work and not for the happenstance of representing an especially unfortunate client whose injuries were caused by a fully-insured, provably negligent defendant. Indigent claimants manage to obtain representation but not because the contingent fee makes the gamble worthwhile for counsel. Their success still results in a fee approved by the court as indicative of the services rendered, not reflective of the magnitude of the award. Usually, the costs assessed against the losing litigant equal about half the attorney's fees of the successful counsel. In most English speaking countries outside of the United States legal fees are based upon the services rendered, not on a percentage of the award. Unquestionably, this is a factor contributing to the low incidence of malpractice litigation in those nations, but to what extent is unknowable. Presumably, a party does not litigate unless his lawyer thinks he has an excellent chance of winning, or because the two sides cannot agree on the settlement figure. Where the loser pays much of the winner's lawyer's fees, a client and his attorney do not file suit with alacrity.

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[5] The Labour Party won the November 1972 New Zealand national election and is now the party in power.

[6] The author interviewed leading solicitors and barristers during November, 1971, as arranged by the New Zealand Law Society, the country's national bar association, and all felt contingent fees to be unacceptable, even barbaric. It is not a proper method for compensating gentlemen, I was led to understand.

So we see that in New Zealand the judicial system is simple and comparatively swift and the lawyers are not overstimulated to indulge in tort and malpractice litigation by the prospects of a huge award and a high fee computed on a percentage basis. Juries tend to be niggardly by American standards. Even taking into account the relative prices and earnings levels, jury awards as published in newspapers would seem to be about a third or a fourth of comparable American judgments. One reason may be the existence of a comprehensive health care program so that the out-of-pocket medical expenses, past and future, for an injured plaintiff cannot be too large. Disability benefits under the Social Security scheme and workers' compensation also help to cushion the financial blow of the injured person. Nevertheless, New Zealanders have expressed sufficient dissatisfaction with the current arrangement for resolving tort claims and other personal injuries to influence the party in power to pledge to simplify the system and eliminate many of its inequities.

THE NATIONAL HEALTH SERVICE

Before considering the development of the proposed no-fault program for handling accident claims, we should examine the country's health care scheme. How the New Zealanders have structured the financing and delivery of health care has a bearing on their approach towards resolving tort and medical malpractice claims.

The present national health care program in New Zealand is the result of an investigating committee, this one in the late 1930's. Organized medicine then claimed that New Zealand medical care was of high quality and the only group having difficulty obtaining service was the poor who sought outpatient care; governmental programs in other counties had not reduced the incidence of illness, the committee was advised. Universal contract practice was to be shunned as the path to lowered standards of practice, said the medical society. What has been stressed over the years by New Zealand physicians is the necessity for doctors to be able to practice in a traditional pattern, with no intrusion upon physician-patient relations by the payment scheme.[7]

At the time a government White Paper on the government role in health care was published in 1938, there was no national plan for prepaying or reimbursing medical or hospital services. Some people belonged to "friendly societies" or other voluntary groups which used the dues to pay all or part of medical and hospital care. The others faced the necessity of cash payment for doctors' fees; the usual office visit then commanded half a guinea, something over one New Zealand dollar in today's currency.[8] Bad debts were commonplace for medical practitioners. Hospital care in public institutions was priced in accordance with the patient's ability to pay and, by statutory provision, fees were reduced or waived for the needy and indigent. Because public hospitals were populated by the poor, they became known as places for persons who had no other choice. Those who could pay chose private hospitals even though they might be less well equipped than the government facilities. Doctors' services were largely donated in public hospitals but were charged for in the private facilities.[9]

Despite the difficulties in collecting their bills, the physicians appeared to prefer fee-for-service practice to participation in any governmental program that could limit fees or determine their income. The recommendations in the 1938 White Paper nevertheless favored government involvement in the compensation of general practitioners. A basic national health program was proposed; it would include (1) universal and free general practitioner services to all, (2) free hospital and mental institution care (3) medications without extra charge, and (4) complete maternity care. At a later date, the report continued, the program should cover specialty services such as anesthesia, laboratory, radiology, and also physical therapy, ambulance, dental and optical benefits. Additionally, there should be home nursing care, domestic help, and a health education campaign, the report concluded.[10]

The resulting Social Security Act of 1938 included pension, social welfare, and health coverage innovations. The two basic premises of its health program were (1) universal coverage irrespective of the individual's income or wealth and (2) eligibility without regard to the amount of taxes, if any, paid by the beneficiary. Among the other health plan objectives articulated in 1938, all have been achieved wholly or to a substantial degree.

Of historical pertinence is the introduction of a voluntary capitation system in 1941. Despite a fairly generous capitation fee, few doctors chose this method of payment. It was replaced the same year with a fee-for-service approach which currently prevails. The physician receives from the government a fixed fee for most office visits, about $.75, a figure unchanged since 1941.[11] Seventy-five cents was about 2/3 to 3/4 of a practitioner's usual charge some 30 years ago. Today it is 1/3 or less.[12] Therefore, the New Zealand system features no deductible but today there is an extremely high percentage of co-insurance. The government is currently considering raising the normal fee. This however, would constitute a burden upon the national budget and become a major political issue.[13]

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[7] For commentary, description, and history of the health benefit program, see *Background Paper; Medical, Specialist, and Pharmaceutical Benefits*, Department of Health, Wellington, November 1969, a submission to The Royal Commission on Social Security. Reprinted in *New Zealand Medical Journal*, January 1970, p. 38.

[8] Throughout this paper the dollar figures shown are New Zealand dollars. Prior to August 15, 1971, the New Zealand dollar was worth $1.12 in American money. Thereafter it hovered around $1.16. After devaluation of the American dollar, it now takes $1.21 to buy a New Zealand dollar. Therefore, the dollar figures shown herein should be increased by about 20% for American equivalents.

[9] See note 7, *supra*.

[10] *Ibid.*

The New Zealand practitioner prepares a daily list of patients he has seen, and their addresses, without identifying their ailments, or treatment received, and certifies to the accuracy of the claim. The regional administrative office of the Department of Health sees to the doctor's payment. The number of government personnel involved is minimal by American bureaucratic standards. Verifying the veracity of the claims is done by a random sampling of one percent of the patients, asking whether they were really treated by the physician on a particular date. Suspect physicians are checked more carefully, even to a 10% sampling of their patients. Meanwhile, the extra fees charged to patients have reflected inflation. Over and above the $.75 from the government, doctors charge varying amounts depending upon the time, skill, and inconvenience involved in rendering the service. A small percentage of physicians, mostly specialists, require the patient to pay them in full; then the patient requests a refund from the government for any allowable fee.

The normal fee paid by the government to physicians goes up to $1.25 for night, Sunday, or holiday service, and "extended time" claims add $.50 for each 15 minutes of attention beyond the first half hour. To lessen the financial burden for poor patients of extra charges by physicians, the normal government fee for treating pensioners and social security beneficiaries has been about doubled. And to encourage rural practice, physicians located in designated areas are paid 10% extra while those who practice in "isolated" areas are on contract with the government, receiving a salary, free housing, office, and car. The patients of the latter pay no fees at all and have no choice of doctor, either.[14]

Over the years the array of health care benefits has been expanded. Any person "ordinarily resident in New Zealand" now has available to him paid in full or in part, (1) general practitioner services, (2) hospital inpatient and outpatient care, (3) drug benefits, (4) x-ray and laboratory diagnostic services, (5) physiotherapy, (6) visiting nurse and home helper services, (7) assists such as artificial limbs, hearing aids, and contact lenses, (8) payment for a specialist consultation, and (9) treatment in public mental hospitals.

MEDICAL SERVICES

The entire national health care system in New Zealand revolves about the general practitioner who dispenses about 75% of physician care in the country. Although the patient may have to pay about $1.50 over the government's contribution for the average visit, this does not deter very many patients who need attention.[15] Once the physician's fee is paid, the patient may avoid all other fees even if he needs to have a prescription filled at the local chemist's (pharmacy), or needs laboratory or x-ray work, or hospitalization. He can arrange for a specialist consultation without additional charge and receive other services at little or no charge.[16] The patient also can face considerable copayment obligations if he uses some private laboratories, specialists not located at a public hospital, or is admitted to a private hospital. Thus, there are two systems conducted in parallel, one for most people and another for those who can or desire to pay for more personalized care.

In the western world, the trend of medicine is towards specialization. In New Zealand, the dominant source of payment, the government health care scheme, has only recently recognized specialization, although it hardly encourages specialists under the present compensation schedule. Specialty medicine outside of public hospitals is of limited coverage. The initial visit of a patient to a specialist, upon referral by a general practitioner, allows a one-time $5 fee. Additional treatment brings the specialist only a general practitioner's level of payment from the government. Nor can he refer the patient to another specialist at government expense; control of the case must first return to the originating general practitioner. Obviously, most specialists need patients who can pay. The exceptions are the independent pathologists, whose tests are paid in full by the government, and self-employed radiologists, whose government benefit runs about half their usual fee. All specialty services are without charge at public hospitals, thus perpetuating a two class system for specialist services. The doctors of New Zealand are alert to developments in medicine in the most advanced countries; not unexpectedly, there is a trend towards specialization. Unquestionably, payment for specialist service benefits will have to be liberalized. The additional costs of expanded specialty services are a political issue; the electorate will have to participate in the decision and in contributing the necessary taxes.[17]

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[11] Remember, add 20% for equivalent American value.

[12] *Paper III; Aspects of the General Medical Services and Specialist Consultation Schemes,* submitted to the Royal Commission on Social Security in September, 1970 by the Department of Health, Wellington.

[13] Interview with Dr. L. M. Jepson, Medical Officer of Health, Christchurch, November 19, 1971.

[14] Note 7, *supra.*

[15] It appears that each New Zealander receives about 4 "services" from general practitioners each year (note 12) and makes one hospital outpatient visit (see *Health in New Zealand*, 1970, Pamphlet No. 161, New Zealand Department of Health, Wellington). This compares with the experience of the Kaiser Foundation Medical Care Program of an average of about 4 doctors' office visits per member per year and the United States average of 4.3 visits per person per year in 1967.

[16] Note 7, *supra.* For a comprehensive and somewhat critical view of the medical care program in New Zealand by a native, see "New Zealand Medical Care," G. M. Emery, M.D., D.P.H., *Medical Care*, Vol. 4, No. 3, July-Sept. 1966, p. 159.

The General Medical Services, that is, the general practitioner system, has been under scrutiny of late. At issue is whether the fee-for-service arrangement is tenable when the patient's out-of-pocket expense is about 2/3 of the fee. In the early days, when the government payment was almost as much as the usual fee—about 88% of it—the possibility of abuse by patient or doctor did exist. As the patient's percentage of payment increased, there has developed a financial deterrent to overutilization by him. For a long time this method of payment had distinct advantages over capitation or government salaries for general practitioners. It permitted free choice of doctor or of patient. Neither was bound to the other by any continuing contract. Also, the "additional fee" schedule rewarded doctors for working on Sundays and holidays, seeing overdemanding patients, and simply putting in a long work week. Physicians could enhance their income by charging for seeing each member of a family on one visit, and arranging to see patients briefly but frequently. Ease of establishing a practice under the heavily subsidized fee system resulted in many urban physicians and few in rural areas.

Now that cash charges to patients are substantial, physicians are reluctant to voluntarily extend a patient's treatment over too many visits; the patients will not submit docilely to a raid on their own pocket books. Yet, the financial incentive in New Zealand is for the physician to prolong the treatment for he is not paid when the patient is healthy. Economic data indicates that New Zealand physicians have kept abreast of inflation not so much by raising fees but, rather, by seeing more patients. Their relative income has been fairly constant over the years. It may well be that they establish a target income and work as hard as is necessary to reach it.[18] Because of steeply graduated income taxes, a physician may find himself paying 2/3 of marginal earnings in taxes and quickly lose incentives to add to his income beyond an optimal level. In a land where successful professionals live comfortably but not luxuriously, and conspicuous consumption is not admired, marginal increases in income are quite resistable.

Free choice of physician has permitted some counterproductive behaviour by patients. They may flit from one doctor to another. In addition to resultant overdoctoring, this results in lack of continuity of medical care, incomplete medical records, and overprescribing of free medications. Nevertheless, a capitation system is not a likely reform in New Zealand because it is unacceptable to organized medicine. However, incentives might be introduced to have patients "register" with a physician in order to receive some special benefits for this pledge of loyalty.[19]

The efficiency of private practioners is a concern of the Department of Health. There was one general practitioner for each 2100 residents in 1969. While this is a better record than in Great Britain, the Department would like the figure to be between 1750 and 2000.[20] An improved ratio of physicians to patients will take time, if it is at all possible of achievement. Meanwhile, it is recognized that efforts must be made to improve the doctor's productivity. He could make greater use of paramedical personnel. Unfortunately for his income, he can claim payment only for services he himself performs, or for work done under his immediate and direct supervision. Under capitation the doctor would lose no income by utilizing ancillary health care workers, but at present in New Zealand, to delegate to those outside his supervision is to lose a fee. So some remedial action is due in this area.

Group practice is another approach to enhanced efficiency of physicians. To encourage the sharing of facilities and personnel, the government is subsidizing the construction of "health centers" and their equipment, as well.[21] At these locations the general practitioners are expected to practice a team approach, with ancillary health and welfare personnel present to assist the doctors. However, group practice in New Zealand does not yet connote prepayment or comprehensive medicine, that is, both general and specialist physicians in the same group. Nor do the group practitioners treat their patients in hospitals. The patient acquires new physicians upon hospitalization, as in Britain.

HOSPITAL SERVICES

The hospital system of New Zealand is 81% public, 19% private, and 100% governmental. That is, both public and private hospital systems function independently of each other, yet the private hospitals are subsidized by government and could not survive without governmental encouragement and financial support. As is the case with regard to medical service, there is no payroll deduction or government operated insurance contribution scheme for hospital care. Taxation, primarily derived from the graduated income tax, pays for governmental support of hospital care.

Most public hospitals were created as local tax supported institutions to serve their communities. Today, there are 31 hospital boards, each controlling the public hospitals within its district. The real estate taxes are of relatively minor support now; most of the operating funds are forwarded to the hospital districts from the capital in Wellington. This is truly a prospective payment system, for out of the annual advances and whatever other sources of income it may have, the hospital board must finance its hospital operations. Many of the facilities are old and outmoded. Without government assistance in the way of capital grants or loans, no new construction, replacement, or modernization is possible.[22]

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[17] The subject of speciality services and how to compensate for them is explored in the paper cited at note 12 and in the Department of Health paper, *Summary of Views and Submissions*, addressed to the Royal Commission on Social Security on May 31, 1971.

[18] As suggested by the Department of Health, note 12, *supra* at page 8.

[19] Note 7, *supra.*

[20] *Ibid.*

[21] See *The Public Health, Report of the Department of Health for the Year Ended 31 March 1971*, p. 75.

Statistically, New Zealand seems overbedded by American standards, although much of the institutional plant is a candidate for replacement. General hospital and maternity beds are at the level of 6 per thousand of population. In addition, private beds contribute 1.3 per thousand. Occupancy generally exceeds 80%. The average length of stay is high by American comparisons—about 15-16 days. This may be explained by the inclusion in the statistics of some long stay diseases such as tuberculosis. The rate of hospitalization also must be affected by the availability of specialists without additional fee only in public hospitals.[23] Diagnostic admissions, as a means of obtaining "free" specialist services, are not uncommon. Also, financial incentives to promote short hospital stays are not built into the system. Assuming a given amount of facilities, money, and personnel to operate the public hospital system, the ones who suffer as a result of unnecessarily lengthy stays are those who are denied admission. In this category are the candidates for elective surgery; they do wait for months to enter a public hospital.[24]

Of the sums expended by the national government to finance the national health service, by far the greatest amount goes to district hospital boards to pay for public hospital operations. In 1970 almost 60% of the Department of Health budget went for grants to district hospital boards.[25] This sum also paid the salaries of hospital-based medical specialists. These are salaried physicians who work part-time or full-time at the institution. They are assigned to patients rather than chosen by them; at public hospitals, physician-specialists are also assigned to patients. Of course, the patient's public hospital services will be paid for in full by the government. Should the patient desire to choose his physician-specialist, and his hospital, too, there is an alternate program available.

PRIVATE HOSPITALS AND HEALTH CARE

Private hospitals exist for those who wish greater personal choice and attention. There one may be served by the medical-specialist he selects, but he will have to pay the requested fee without governmental help, and much of the hospital bill, as well. Who are these independent specialists, these free enterprise devotees? Most of them are the same physicians who serve at public hospitals. If a specialist works only 7/10 of a full schedule at the public hospital, he is considered to be a part-time employee and is permitted to have a private practice at his outside office and at a private hospital. To be sure, there may be occasions when a potential patient at a public hospital, in order to be treated by the specialist of his preference, will arrange to see the same public hospital specialist in the latter's private practice at the patient's expense. The integrity of New Zealand gentlemen is the built-in protection against abuse in these instances. In New Zealand, the prospect of abuse of confidence and of conflicting interests is not greatly feared because professional men who are products of the English-style educational system generally can be relied upon to be fair even in the face of temptation. And if they are not, the professional societies and government will react to discourage the inequitable practice.

Private hospitals are not merely tolerated. They are an integral part of the national health service in New Zealand. Were the government to replace them, the needed capital expenditure would be fearsome. Furthermore, the financial arrangement between the government and private hospitals currently is in the public favor. The government pays $9 a day towards surgical and maternity care in private hospitals, the balance of the charges being the patient's responsibility. The hospital's charges are subject to governmental scrutiny. It would cost the government at least $25 a day to provide comparable medical and hospital services in a public hospital, hence the clear benefit to the exchequer.

Although most private hospitals are old structures, often church-sponsored, there are good reasons for an individual to opt for private care. These hospitals tend to be less noisy than public hospitals, operated on a smaller, more homey scale, and admission can be arranged at the convenience of the patient. By selecting his own physician, the private patient who is paying the doctor directly may find him more solicitous.

Recognizing that the capital already invested in private hospitals relieves the public of a similar expenditure, the government not only condones private hospitals, it provides capital funds for their alteration or expansion. Loans are provided for approved projects at less than the prevailing commercial interest rate and some of the interest may be suspended or cancelled if the hospital continues to operate for at least 10 years.[26]

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[22] Statistical information about hospitals in New Zealand is available in the pamphlets and annual reports of the Department of Health, and in *Hospital Statistics of New Zealand*, which supplements the Department's annual report.

[23] The Department of Health is conscious of the possible reduction of hospitalization rates if more generous outpatient specialist diagnostic and consultation service benefits were made available. Note 12, *supra.*

[24] Information furnished during extensive interviews concerning the hospital system with Dr. L. McH. Berry, Medical Superintendent in Chief and Dr. Ross Fairgray, Assistant Superintendent, The Christchurch Hospital, Christchurch, November 18, 1971.

[25] *Health in New Zealand, 1970*, note 15, *supra.*

Were it not for the growing number of enrollees in private health insurance plans, the future of private hospitals and the independent practitioners who bring patients to them would be rather insecure. As in England, there is a demand for a choice; some persons who pay for the national health service through heavy income taxation are willing to pay once more to insure the availability of funds to compensate private physicians, in and out of hospitals, and pay private hospital fees. In the last few years a couple of prepaid plans have grown rapidly. Southern Cross Medical Care Society and the Manchester Unity plan have filled a waiting need, along with some industrial union programs and friendly societies. Southern Cross already has over 150,000 members who pay around $10.50 a year for what appears to be an exceptional bargain. Benefits include payment for those fees not covered by the government, including as much as 80% of: hospital costs, fees of surgeons and anesthesiologists, laboratory tests, optician's charges, physiotherapy, and general practitioner fees. An annual ceiling on benefits for a prescriber usually applies, however.[27]

So, it is clear that a substantial and growing amount of health care is being financed outside the government health plan, perhaps 5-10%. This not only permits freedom of choice not otherwise feasible, but also restrains the ever mounting cost of the generous government program. The expenditures for all health care in New Zealand are in the vicinity of 5% of the gross national product.[28] This compares with the current American figure of about 7%. These statistics are rough, to be sure, but credible. One could venture a guess that the 2% difference between the countries is represented by capital investment and compensation of physicians. The physical plant in New Zealand, it appears, is not being replaced or renovated as fast as Americans would do it and the doctors, most of whom are general practitioners, probably are not as well compensated for their services, in relation to the rest of the working population, as are American physicians.

QUALITY OF HEALTH CARE

How can we judge the effectiveness of the New Zealand health care system? We have seen that there are, by American reference, a surfeit of beds per population and comparatively lengthy average hospital stays. Some 118 persons per thousand became inpatients in 1970 and 1160 per thousand sought hospital outpatient care. On the other hand, the cost to the hospital of an average hospital stay was only about $250 and the cost per patient day was under $17.[29] Perhaps at these rates lengthy stays are both tenable and justifiable.

New Zealand is reasonably well supplied with doctors. There are 830 persons for each physician holding a current certificate to practice (although all the doctors do not see patients). The statistics as to their impact upon public health are impressive. Maternal mortality in 1969 was .24 per 1000 live births. Infant deaths per 1000 live births were 10.8 for neonates and 6.1 for postneonates. In all cases, the non-white population had a poorer record.[30] With over 90% of the population of British stock, a healthful environment, and adequate food, there are favorable conditions for health irrespective of medical care. Yet, the healthy condition of New Zealand's population must be attributed in part to the quality of the providers of health care and their ability to function satisfactorily under the national health service arrangement.

It should be noted that the entire administration of the national health service requires only a few hundred employees at the national government level. Avoiding the insurance mechanism surely has saved New Zealand much money in administrative costs over the years.

While the dental care responsibility of government is limited, it is carefully aimed; 13-16 year old school children are afforded dental services by private dentists under a fee-for-service schedule negotiated by the government and the New Zealand Dental Association as a Social Security Act benefit. This program, plus fluoridation and dental health education, is beginning to produce dividends. A simultaneous program of school dental care provided by dental nurses who diagnose and repair, even doing extractions and filling of cavities, is improving the dental health of younger school children.[31] Most adults, it appears, have no prepaid or government subsidized dental care.

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[26] Details of the private hospital and practitioners' services provided in interviews with E.G. Heggie, Deputy Director-General of Health (Admin.), Wellington, November 12, 1971; Dr. L. M. Jepson, Medical Officer of Health, Christchurch; Douglas Ross Smith, Administrator, St. George's Private Hospital and Dr. L. A. Bennett, Chairman of the hospital board, Christchurch; Dr. L. C. L. Averill and Dr. J. G. Laurensin, Chairman and Secretary, respectively, of the North Canterbury Hospital Board, Christchurch, November 19, 1971.

[27] Dr. Jepson and Mr. Smith, cited in note 26, *supra*, were especially informative about the private health care plans.

[28] Figures interpolated from 1970 statistics contained in *The New Zealand Official Year Books*.

[29] Note 15, *supra*.

[30] For New Zealand statistics see *Trends: Health and Health Services*, Department of Health, Wellington, 1969 Edition. Comparable American figures available in *Statistical Abstract of the United States* are:

- Hospital admissions, 149 per 1000 population (1969)
- 666 persons per "active" physician (1969)
- Maternal deaths per 1000 live births, 24.5 (1968)
Neonatal deaths per 1000 live births, 16.1 (1968)
Fetal deaths per 1000 live births, 15.8 (1968)
- Total infant mortality per 1000 live births 21.8 (1968) (excluding fetal deaths)

From the foregoing one learns that the New Zealand solution to financing and organizing health care is an evolutionary arrangement which allows free choice of general practitioner, no direct fee controls by government,[32] substantial copayment by the patient for medical services, and very limited private specialist benefits. Hospital care is government financed in public hospitals and includes inpatient medical services, while private hospitals are permitted and subsidized. Supplemental private prepaid health plans are growing. Improvements in the scope of government financed benefits are made periodically, depending upon the national budget and political mood.

MEDICAL MALPRACTICE

On the whole, New Zealanders seem content with the mechanism of their health care payment system and the quality of care received (if not with the high taxes required). At least, few serious complaints are transmitted to an inquiring visitor. But when there is a dissatisfaction by a patient, how does he express himself? In the United States a patient might complain to the medical society at the city, county, state or national level, or to the medical licensing body. Only a grievous offense, generally a breach of ethics, alcoholism or drug addiction, is likely to stimulate punitive action. A mere error in medical judgment or performance—malpractice—requires a lawsuit to bring compensation to the aggrieved patient. This is not unlike the New Zealand grievance apparatus. However, in each district in New Zealand there is a medical officer of health, a representative of the national government to whom complaints may be directed by those who are unhappy with aspects of the national health service, including the quality of treatment. Informal disciplinary inquiries are then undertaken by this official and the national medical society. Any corrective action may well be a confidential matter between the Department of Health and the medical profession. There need be no public notice if the patient is not to be compensated.[33]

On rare occasions there may be legal action taken by a patient. Leaders of the bar have difficulty remembering instances of medical malpractice litigation although they freely admit such actions do occur.[34] It must be remembered that New Zealanders are not particularly litigious. The consequences of losing a suit include payment of court determined costs, encompassing much of the other party's attorney's fees. Also, jury awards are modest, so the prospect of a big payoff is remote. Doctors are still respected, well known community figures, and there is a reluctance to sue them or for juries to hold against them. And, of course, the absence of contingent fees means the gambler's odds are removed from the motivation of attorneys and prospective plaintiffs.

Insurance for medical malpractice risks is not readily available from carriers in New Zealand. Therefore, coverage is provided by the two mutual benefit societies in London that protect British doctors. Some 90% of New Zealand practitioners subscribe to the Medical Protection Society and the Medical Defense Union. Unlimited coverage costs but $28 a year, up $2 from last year, yet enough to allow the program to operate in the black. Obviously, the number of claims and the amounts of judgments must be minimal. By American comparisons, they are. Of an average of 80 medicolegal claims a year in New Zealand, only 50 reach the stage of lawyer involvement. Some 20 of these are dropped for lack of merit and another 10 are settled for a few hundred dollars up to $15,000. The remaining 20 are defended by the Society; the defense generally prevails.

One reason for the low premiums is the sharing of most of claims arising in hospitals, which includes most of the serious ones, with the hospital's carrier. Joint liability of hospital and physician usually results in sharing of the financial responsibility by the physician's carrier and the State Insurance Office as insurer of public hospitals. Even a "vegetable" case, the most costly, is not likely to bring a claim for more than $90,000. Judgment levels are expected to increase, though, and premiums will be suitably revised.[35]

THE PATH TOWARDS NO-FAULT

Knowledgeable observers in New Zealand agree that tort litigation is a poor mechanism for identifying and compensating victims of malpractice. Tort litigation is not satisfactory for resolving controversies arising from industrial injuries and automobile accidents, either. A search for better methods of handling these social concerns has led to the novel New Zealand legislative proposal for a no-fault, no-court system for compensating victims of personal injury, now before the Parliament and expected to become law during 1972, effective in 1973. While only a small portion of this broad scope program touches upon medical malpractice, knowledge of the history, considerations, reports, and reactions to the scheme can be of help to us. Especially interested would be those who are considering a no-fault approach to resolving malpractice disputes in America.

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[31] See comments on dental services in departmental report, note 21, *supra*, at pp. 37-39.

[32] The medical society, it is suspected, restrains its members' desires to raise fees if such increases may stimulate unfavorable reaction by the government.

[33] Interview with Dr. L. M. Jepson, note 26, *supra*.

[34] Interviews at The Law Society, Wellington, November 12, 1971.

[35] Information on malpractice insurance provided by Mr. G. Lee, Secretary, Medical Association of New Zealand, and transmitted via letter to the author by Mr. W. M. Rodgers, Secretary, The Law Society, Wellington, February 29, 1972.

The Royal Commission of Inquiry was appointed in 1966, in the name of the Queen, to investigate injuries related to employment—worker's compensation—and to report on possible improvements. The New Zealand system permits the injured worker to claim no-fault benefits or sue at common law if he can prove negligence, carrying on both claims until the more lucrative choice can be made. The common law action is inherently risky but potentially more remunerative than the very low schedule of benefits available to those who cannot prove fault. Compulsory automobile liability is another feature of New Zealand law. When the annual automobile license is renewed, part of the government fee is for insurance from a company of the insured's choice. An injured person who cannot qualify for an employment-related award or prove negligence in an automobile accident claim may obtain social security benefits, although there is a means test. At best however, social security payments would provide mere subsistence. Occasionally, an injured person can recover under two or more of these payment schemes.

The Commission decided, initially, that it could not restrict its consideration to compensation of industrial accidents. The happenstance of where the injury was incurred is virtually irrelevant, it found. All personal injuries would have to be considered and their harmful consequences recognized and alleviated. Therefore, when the Commission's report was published in December, 1967, it was entitled "Compensation for Personal Injury in New Zealand."[36] Chaired by Supreme Court Judge A. O. Woodhouse, the three-member group found inexcusable the fragmented approach to compensating victims of accidents. Particularly offensive was the "lottery" aspect of negligence suits.

The Commission's disappointment in the common law trial as a means of settling accident cases was not without recognition of its usefulness in the past. Successful litigants, the Commission conceded, receive full payment for their past and future losses; over the course of time, awards reflect inflation and changing public opinion; and the fear of an adverse judgment helps to deter the committing of negligent acts. A successful common law action, on the average, brings three times as much as a worker's compensation claim for the same injury in New Zealand and, the Commission stated, the incident may occur almost anywhere and at any time and still be actionable at common law.

The defects of the tort system, however, are many, the Commission found. First, there is the fortuity of the injured person having been the victim of provable negligence by a judgment-worthy defendant. His contributory negligence may substantially reduce the award. Damages are lump sums, thus delaying settlement or trial until all foreseeable injuries and costs are known. Once the settlement or judgment is obtained, there is no adjustment for improvement or worsening of the plaintiff's condition. The trial itself is slow and expensive and this encourages poor plaintiffs to settle prematurely or innocent defendants to pay something rather than face trial. Where automobile insurance coverage is universal, as it is in New Zealand, the matter of fault really should be irrelevant; the risk of accidental injury should be borne by the whole community, the Commission contended. Even after the long delays and much anxiety, successful litigants receive only about 60% of the money going into the system in New Zealand—the balance is for "administration." While the foregoing describes the situation in New Zealand as of 1967, most of the derogatory features could apply equally well to the United States, where there is also the contingent attorney's fee to add to the questionable features of litigation over accidents.

The worker's compensation scheme also attracted criticism from the Royal Commission. Again, its dissatisfaction was for reasons that could very well apply to the American system. (1) Benefits are inadequate to restore the disabled worker's purchasing power. (2) A long term disability could continue after maximum payments have been exhausted. (3) Lump sum payments are permitted and often prove unwise for the worker. (4) The schedule of injury payments reflects the disability rather than diminished earning capacity of the injured person. (5) Less seriously injured insureds are relatively favored over the serverely disabled. (6) Whether the injury arose in or out of the course of employment is sometimes difficult to determine. (7) The insurance carriers use up 30% of the premiums for their expenses; furthermore, their interests are often contrary to those of the injured workers, so their continued role in a social welfare scheme of this kind is of doubtful justification. (8) The claims procedure has become terribly legalistic, adopting many of the undesirable time-consuming aspects of court cases.

After observing that non-earners, like housewives, suffer expensive accidental injuries, the Commission recommended:

– Comprehensive entitlement and equal recovery for equal loss.

– Recognizing the injury, not its cause, as the determinant of entitlement.

– Self-employed and non-employed persons, such as housewives, need coverage for economic consequences of accidental injuries.

– As a means of avoiding malingering, saving administrative costs, and preserving funds for victims of serious injuries, minor injuries and loss should receive little or no compensation.

– Payments should be periodic and adjusted to meet the cost of living and the physical condition of the injured person.

– Costs to employers, insureds, and others should not be raised much above their present level.

– Insurance companies should not be allowed to handle the nationwide scheme for accident reparations any more than they would be permitted to administer the social security or health care program. The program should be administered by an independent government agency.

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[36] *Compensation for Personal Injury in New Zealand; Report of the Royal Commission of Inquiry*, December 1967, Wellington.

– Compensation should take into account permanent physical disability and loss of income, with payments normally made periodically, even for life, and commuted to lump sums only in special cases.

– Physical and vocational rehabilitation should be an integral part of the plan; and prevention of accidents should be, too.

– Accidents should be compensable no matter where or at what time of day they occur, and, most important, without proof of fault.

The report does not propose no-fault compensation for sickness and disease, just for accidental injury. It recognizes the lack of logic in excluding consequences of illness inasmuch as the loss of income from ailments is as real as from accidents. Logic may have to give way to expediency, the Commissioners admit, because of doubts as to the administrative possibility of a no-fault recompense program covering disease and disability not connected with an accident.[37] Difficulty in identifying the compensable event dictated this position. Nevertheless, the report specifically leaves open the extension of the program to non-accidental sickness and disease at a future date.

The "Woodhouse Report" as the Commissions effort has become known, attracted attention rather slowly. But now, after further governmental inquiries, hearings, and often intense reactions from interested parties, some of its recommendations are about to become law. Of special interest to those concerned about reforming the medical malpractice mechanisms in this country are these comments of the Royal Commission:

- It is "external" causes of injury that are to be compensated but excluding suicide "and some categories of therapeutic misadventure".
- Hard cases" are expected under this standard although most situations would be fairly clean-cut. Injury is to be compensated if it is the result of "unexpected or undesigned external cause," including exposure to the element or noise, great physical strain poisoning, one's voluntary act and emergencies, and all presently covered industrial diseases.
- Non-covered incapacities would be those resulting from "a condition of disease or sickness," "a sudden physiological change in the course of" a sickness, or "a physiological event occurring during activity which itself was normal and uneventful," and self-inflicted injuries.
- Drawing the line between injury by accident and mere sickness is a mixed question of law and medicine; a group of representatives of each profession should study this problem area.[38]

Because of the vagueness of the Commission's report as to whether medical malpractice was meant to be covered, the author interviewed a number of leading members of the New Zealand Bar regarding their understanding of its intent. They had not given the question any previous thought—perhaps a true reflection of the limited concern with such litigation—and thought some incidents now considered malpractice might be classified as accidents under the Commission's proposal. In a further attempt to resolve the issue, the author put certain questions to Judge Woodhouse, then sitting on the Court of Appeal, the country's highest tribunal. He responded that the Commission's objective was to classify as accidents those misadventures in medical care that are unanticipated and unplanned. Thus, he would compensate as an accident such injuries as those resulting from a patient's fall in the doctor's waiting room, or from too tight a strap on the examining table, or from failure of equipment, like a broken hypodermic needle. An unusual reaction to a drug, not readily anticipated and preventable, would be an accident in the Judge's estimation. So would the adverse consequences of "nitrate" being read by health care personnel as "nitrite," or vice versa. Even an error in professional judgment by the physician, acknowledged as the cause of harm to the patient, would qualify as an accident under Judge Woodhouse's concept of a no-fault accident reparation scheme. He does stop short and concedes indecision in the case of a patient who, after merely being seen or treated by the physician, is worse off, to the extent of disability. Inasmuch as this condition could have resulted without any accident—that is, negligence, inadvertence, or untoward event—it probably would not be compensable. The Judge is confessedly uneasy about where to draw the line, recognizing that a boundary is necessary, but he would be willing to let the fact finder hear cases falling within the "gray area."[39]

A government White Paper then reviewed the Woodhouse Report and was published in Ocotber 1969.[40] It thoroughly considered each proposal and commented on its feasibility. On the whole, the Commission's report fared well. However, with regard to the exclusion of sickness and disease, and the possible exclusion of "therapeutic misadventures," the authors of the government White Paper were uncomfortable. They were troubled by how to classify heart attacks; does the time of occurrence determine coverage or exclusion? If one is overexposed to the elements on his own time and contracts pneumonia or frost bite, is he to be compensated? Are mental, nervous, and even hysterical conditions compensable only if related to an accident? It was suggested that this problem area be given over to still another special committee. This group would ascertain whether the use of World Health Organization classifications of "external causes of diseases" is practical in this respect. One category of such accidents is E930-E936,

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[37] *Ibid.*, at p. 26.

[38] *Ibid.* at pp. 113-114.

[39] Interview with Judge A. O. Woodhouse in his chambers, Court of Appeal, Wellington, November 12, 1971.

[40] *Personal Injury; A Commentary on the Report of the Royal Commission of Inquiry into Compensation for Personal Injury in New Zealand*, Wellington, October 1969.

"surgical and medical complications and misadventures." At issue would be whether a particular condition is an (externally caused) injury—a medical question—and then, whether it is an injury fitting within the WHO classification of accidents. In this way the line between covered accident and excluded disease could be drawn.[41]

The government's commentary upon the Woodhouse Report's proposals do not seriously doubt its feasibility. In fact, administering the program is estimated at 11% of the administering agency's total financial needs, a far cry from the 30% current overhead in worker's compensation in New Zealand and perhaps 40% in automobile injury coverage.

The House of Representatives, immediately upon receiving the White Paper in October of 1969, approved the creation of a Select Committee on Compensation for Personal Injury to hold hearings during the legislative recess and report back to the House. Of its 10 members, 6 were chosen by the Prime Minister and 4 by the Leader of the Opposition—all members of Parliament. After an extension of time, the Committee's report was submitted a year later in October 1970.[42] It recommended restricting the proposed changes for use of the no-fault system to compensating accidents arising out of employment and self-employment and use of automobiles. The Royal Commission's program for covering accidents of non-earners was dropped from the recommendation. Yet, the proposals would be quite an innovation. Reflecting the realities of politics, a place for insurance companies would be preserved—as fee-for-service intermediaries administering parts of the program for the government. No additional general taxation would be necessary since workmen's compensation type premiums would continue, as would compulsory automobile liability insurance. The other victims of accidents would have to await alterations in the Social Security Act to determine the scope of their benefits, the Parliamentarians suggested.

The Parliamentary committee noted the similarity of needs of victims of accidents and of illness. Some day, it contemplated, a single administration could compensate for accidents and all other causes of need, including illness. Then there would be no need to make medically difficult distinctions between ailments that are accidental in origin or are merely the result of sickness. For the present, though, the no-fault scheme should cover only injuries of employed persons and from use of automobiles, the report concluded.

The reader may wonder whether the lawyers, physicians, insurers, and others whose interest and livelihoods were at stake sat by without comment or action while the various government bodies planned the no-fault reform measures. Not at all. Once it became clear that the proposals for no-fault reparations for accidents were not idle academic dabblings, the vested interests reacted in their self-interest, although in New Zealand self-interest can be tempered with genuine public concern. The Parliamentary committee conducted public hearings and heard submissions from affected organizations. The compromising nature of its recommendations probably reflects the impressions made by the pressure groups.[43]

The primary contention concerned abolition of the common law tort remedy for industrial, automobile, or other accidents. The largest medical society preferred retention of the common law action but others opposed it because pending litigation often impedes the patient's rehabilitation and the adversary system is unkind to medical witnesses. The New Zealand Law Society was almost equally divided between proponents and opponents of the no-fault concept, hence it was incapable of speaking for the profession. Still, its spokesmen testified to a preference for the new system to apply only to work-related accidents, fearing the cost estimates previously proferred for no-fault programs were unrealistic and also proposing that payments maintain 80% of the worker's income in addition to a schedule to compensate for pain and suffering. The division of opinion among New Zealand's lawyers, ordinarily an effective pressure group, was a major factor in allowing the no-fault proposal to proceed to the legislative drafting stage. The insurance industry, in contrast, preserved a possible role for itself as fiscal and administrative intermediary in the proposal emerging from the Parliamentary committee. Nevertheless, most lawyers do not face a serious loss of business. They are paid for their actual work, not on a contingent fee basis. Even under no-fault there would continue to be disputes as to eligibility and the amount of the award, so lawyers would still derive income from accident cases. Under common law in New Zealand today, many suits are tried because of disagreement as to the level of damages, not to determine the defendant's liability.[44]

THE NO-FAULT BILL

Consequently, by late 1971, the National Party had committed itself to the program espoused by the Parliamentary committee. The Labour Party approved and would have gone even further if permitted.[45] The bill writers were engaged to prepare the text to carrying out much of the Royal Commission's program and the measure was introduced in Parliament before year's end.[46] The notable absence is no-fault coverage for those injured other than in connection with automobiles or who are not employees or self-employed. "Non-earners" would not be covered, probably for fear of the cost of such a program. They would have to await rescue by Social Security Act improvements which could come in a year or two. A new and independent government agency, the Accident Compensation Commission, would administer the program, approving payments upon proof of injury "by accident" suffered by an "earner" or in relation to a motor vehicle, at any time of day or at any location. Certain wage earners would be eligible only for work-related compensation, however. After seven days of disability a successful claimant would be entitled to income maintenance payments for up to 80% of lost earnings, compensation for loss not related to earnings (pleasures of life) if permanently injured (with a $12,500 limit), and costs of medical care not financed by the government health care program. "Wrongful death" type benefits accrue to surviving dependents of covered persons, also.

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[41] *Ibid.*, at pp. 96-97.

[42] *Report of Select Committee on Compensation for Personal Injury in New Zealand*, Wellington, October 1970.

[43] Summations of the submissions of the interested organizations to the Select Committee of Parliament are included in Appendix C of the Committee's report, *Ibid.*

[44] Discussion with personal injury law practitioners in Wellington, November 12, 1971, notably C. Evans Scott, Esq. and A. Eaton Hurley, Esq.

[45] The Labour Party, now in power, is reportedly talking of extending the law to include compensation to non-employed persons, particularly to housewives.

[46] *Accident Compensation Bill*, No. 146-1, introduced by Rt. Hon. Mr. Marshall.

The National Party has the votes to pass the bill if there is full loyalty among its members in Parliament.[47] And it needs to demonstrate to the public, before the November 1972 election, that it, as well as the opposition Labour Party, can improve the social welfare. Consequently, the no-fault theory will become actual practice when the Act becomes effective in October 1973,[48] the target date. The no-fault principle will apply on a 24-hour coverage basis only to automobile related injuries and accidental injuries of most "earners." There is no requirement for fully eligible persons that the accident occur at work or going to and from work. Therefore, if an earner is injured through accident in connection with receiving health care, section 67(7) of the bill allows one "to recover compensation in respect of a disease if the disease is a personal injury by accident within the meaning of this Act." Clearly, we will have a test situation as to the feasibility of a "no-fault accident" approach to at least part of the malpractice problem because of this provision. That is, inevitably, there will be a collection of adjudicated claims delineating the boundary between accidental medical misadventure on one hand and sickness and disability which is held not personal injury by accident, on the other. Of course diseases arising out of employment will be covered as they are now. Conventional common law negligence litigation will remain, one may presume, for the injured patient who insists he was the victim of medical malpractice not constituting an accident. For "non-earners," this will remain their only possible source of compensation, if the injury is not work-related, unless the social security benefits are later enhanced to provide them with lost revenue and amenities of life. And should the court determine that the illness was the result of an "accident", the case will be dismissed and be removed to the no-fault arena. If the Commission finds no accident, the claimant must return to the courts to prove negligence, a potential *renvoi*. Obviously, the medical malpractice area will present conceptual problems in ascertaining the proper forum.

Although the Accident Compensation Bill has been introduced in Parliament, many of its sections are incomplete and bear the notation, "to come." A Supplementary Order Paper will soon be added with more clauses and missing provisions. Meanwhile, the Select Committee of Parliament is in being, exercising its continued interest, and will receive comments on the bill from interested parties. One more group, the Expert Committee, has been appointed to prepare schedules of compensation for particular injuries and treat the practical problems of coverage of the payment scheme. This body will include three physicians and three attorneys.[49]

In its present form the bill is 110 pages long and is replete with detail about the administering Commission (one of the three Commissioners is to be a lawyer) and its functions; collection and distribution of funds; benefits, including medical care, rehabilitation, periodic and lump sum payments; claims and appeals procedure, even to the highest court on issues of law. Necessary exceptions, special situations, and unusual circumstances are treated in the legislative draft. What appears to have been omitted, intentionally, is any statutory definition of "accident."

It may yet come to pass that the most effective remedies for the ills of our tort reparation system will be disclosed by demonstration, in an attractive, usually tranquil, and very civilized little country half-a-world away from the troubled industrial societies with which it shares a common legal heritage. Perhaps it is too much to be hoped for, but New Zealand's experiment may indicate whether no-fault concepts are at all feasible for identifying the compensable event in medical malpractice controversies and properly rewarding the claimant. The developments "down under" thus merit our most careful and continuing observation.

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[47] The act was passed October 20, 1972.

[48] The new government may implement the act section by section rather than all at once.

[49] Current information furnished in correspondence from W. M. Rodgers, Secretary, New Zealand Law Society, Wellington, 29 February, 1972.

MEDICAL MALPRACTICE IN CANADA

Rebecca Welch

Summary

Medical and legal experts in Canada cite a variety of reasons for the lower level of medical malpractice activity compared to medical malpractice activity in the United States:

- Health care costs for Canadians are borne largely by a government compensation system.
- Canadian physicians are protective and tightly organized through their medical association.

- The potential malpractice plaintiff in Canada cannot benefit from a *res ipsa loquitur* doctrine, and in addition, he is more likely than his American counterpart to have difficulty in obtaining medical testimony.
- Canadian malpractice cases generally are tried before a judge, alone, rather than before a jury.
- Most Canadian provinces have short statutes of limitations which commence from the date treatment of the condition in question terminated rather than from the date the alleged medical injury occurred.
- The vast majority of Canadian malpractice plaintiffs must pay their lawyer, win or lose, and if they lose they must pay a portion of the defense costs as well.
- The climate of opinion in Canada, both among judges and the general public, reportedly tends to be more sympathetic toward physicians than public and judicial opinion in the United States.

The practice of medicine in Canada and the United States well may be similar, but in light of the differences cited above, one can understand why each country has had a different experience with medical malpractice claims and suits.

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Considering the similarities between Canada and the United States in regard to population composition, quality

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of education, ratio of physicians to population,[1] and medical techniques taught and practiced, the proportionate volume of medical mishaps should be fairly comparable between the two countries. However, while the volume and size of malpractice claims and suits in the United States has grown to the point where the malpractice problem is said to be of major proportions, malpractice suits are relatively infrequent in Canada and malpractice insurance for Canadian physicians costs only $50 per year.

According to Law Professor A.M. Linden of York University in Ontario, only 80 writs (documents issued by Canadian courts when suits are filed) were issued in 1970 against members of the Canadian Medical Protective Association, which represents some 22,000 of Canada's 28,000 physicians. Only 43 of these writs resulted in actual trials. Of those cases that went to trial, 35 were dismissed and only 8 were successful.

Like American hospitals, Canadian hospitals are insured for malpractice liability by private insurance carriers, either under group coverage within each of the provinces or through individual policies. Malpractice claims against Canadian hospitals, like those against Canadian physicians, however, are much less frequent and involve smaller awards than hospital malpractice claims in the United States. One Canadian insurance company which underwrites 45 hospitals under the Manitoba Hospital Association program, for example, maintained a total amount reserved for outstanding claims in 1971 of only $12,000.

Preliminary data from a study by the Canadian Hospital Association (CHA) of the number of malpractice actions against hospitals in various Canadian provinces in 1971 found that the volume of such actions has been relatively low. Only seven actions were brought in the province of Manitoba in 1971. Four of these were pending at the time of the study and three cases had been closed with only out-of-pocket patient expenses awarded: $181 for a suicide and $87.85 and $67.50 for two incidents of alleged improper treatment. No malpractice actions against hospitals were reported for Prince Edward Island or the Northwest Territories for 1971. In Alberta, according to the study, eight malpractice actions were taken against hospitals, but only two of them resulted in payment and the sums paid were small: $54.40 in the case of a cardiac arrest and $60 in another case.

Of those Quebec hospitals responding to the CHA survey, forty indicated they had sustained no malpractice actions during 1971, three reported one action each, four reported two each, three reported three each, one reported four actions, and one reported seven actions. One hospital that did not report its malpractice experience for the year 1971 separately did report that it had sustained a total of 23 malpractice actions between June 1969 and August 1972. The majority of those twenty-three actions, however, resulted in no payment or payment of less than $100. Fewer than 10 awards over $5,000 were reported in all of Quebec for 1971.

At the time of this writing, the Ontario Hospital Association had not yet responded to the CHA survey, but a spokesman for the CHA estimated that some 150 claims were filed against Ontario hospitals in 1971.

In examining the overall malpractice claims record in Canada, even taking into consideration the somewhat higher frequency of claims against hospitals in Ontario, one may conclude that the volume of medical malpractice claims in Canada appears to be quite low in comparison to the volume of malpractice claims in the United States, which was estimated to be approximately 12,800 claims in 1970.[2] Many Americans concerned over the volume of medical malpractice claims in the United States have wondered why Canada's claim record is so superior to our own.

Mr. Lorne E. Rozovsky, Departmental Solicitor of the Hospital Insurance Commission in Halifax, Nova Scotia and president of the Nova Scotia Medical-Legal Society, testified about medical malpractice in Canada during the public hearings held by the Department of Health, Education and Welfare Secretary's Commission on Medical Malpractice (SCMM). In addition, deans of law schools and medical schools throughout Canada were contacted by letter and asked for their views on why the Canadian medical malpractice problem is so slight compared to the malpractice problem in the United States. The following suggested explanations for the disparity between the volume of malpractice claims in the United States and Canada were drawn from information supplied by Mr. Rozovsky and from the letters that were received in responses to our letter to the medical and law deans.

NATIONAL HEALTH CARE INSURANCE REDUCES THE NEED FOR COMPENSATION FOR MEDICAL INJURY.

The Canadian hospital health care program covers 98.9% of the Canadian population and provides payment for all medically necessary hospital services. It is financed by equal contributions from the National and provincial governments. The province funding is provided through general revenues, payroll deductions from both employees and employers, and premiums from individuals or welfare. In the provinces that require individual contributions, the cost is usually from $11 to $15 per month per family. The hospitalization coverage under the Canadian program is much broader than coverage under Medicare Part A in the United States: There are no age restrictions or work requirements, no annual "deductibles," no limits to necessary hospital days covered and fewer exemptions to covered services. The Canadian coverage is based on the all-inclusive daily standard ward rate that has been approved by the authority of each individual province. Services rendered are not tabulated separately and overbilling and large fee items have been essentially eliminated.

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[1] According to the American Medical Association, the ratio of active physicians directly involved in patient care to people in the United States in 1970 was one to 730, not greatly different from the corresponding Canadian ratio of one physician to every 808 people.

[2] See "Medical Malpractice Insurance Claims Files Closed in 1970," *Supra,* pp. 1ff.

According to Dr. John R. Gutelius, Dean of the Medical School of the University of Sasketchewan, "This overall system has eliminated whatever stimulus to sue may arise from the sudden realization by the patient that he has a very large bill which he would have trouble meeting." In addition, Dr. Gutelius points out that the absence of hospital bills reduces the awards in malpractice cases because plaintiffs have smaller "specialized damages" to claim.

The Canadian health care program's coverage of physicians services is similar to the coverage provided elderly people in the United States under Part B of Medicare. Again however, there are no age restrictions to eligibility. The excepted services under Medicare Part B and the Canadian health care program are similar, and freedom of choice for both the patient and physician is protected. Physicians are paid directly with government funds if they are participants in the various provincial plans. When non-participant physicians are used, payment is channeled through the patient to the doctor. Eighty-five percent of all medically required services are paid under the Canadian program. Commercial health insurance is available to provide protection for expense generated by the remaining 15% of medical care costs.

THE STRENGTH OF THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION DISCOURAGES CLAIMS.

A possible partial explanation for the relatively small number of medical malpractice actions against Canadian physicians lies in the role of the Canadian Medical Protective Associaiton (CMPA). This professional organization is financed by a $50 annual dues assessment from each member physician. It represents over 78% of all licensed physicians in Canada.

One of the membership services of the CMPA is provision of advice and counsel in malpractice matters. The Association offers advice on the best way to avoid suit when threats have been made, handles the actual defense of the suit and the payment of defense costs, and pays damages, should any be assessed. Those physicians who inquire about commercial insurance are told that as long as they maintain membership in the CMPA they do not require commercial insurance which, if carried, actually may introduce needless complications. A member who has been threatened with a malpractice claim notifies the Association of the pertinent information surrounding the case and is then requested not to discuss the case further with the patient or the patient's attorney.

The CMPA takes the position that a defensible case should be defended in court rather than compromised, regardless of economic considerations. Professor Linden, previously quoted, wrote, "They defend vigorously and rarely pay anything except in the clearest of cases. . . ."

The CMPA has spent large sums defending cases that could have been settled less expensively out of court, but its strong resolve to defend malpractice cases appears to have had a great dissuading effect on the bringing of "nuisance" claims by potential plaintiffs and their lawyers. In addition, the CMPA's policy of going to court in nearly every case, thus requiring the defendant physician to justify his professional performance with testimony and undergo cross-examination, may tend to encourage caution on the part of physicians, who do not relish having to account for questionable professional behavior before their colleagues.

CANADIAN COURTS DO NOT ACCEPT THE *RES IPSA LOQUITUR* DOCTRINE

In Canada, the plaintiff in a medical malpractice suit must prove, through affirmative evidence in court, that he was medically harmed and that his injury was caused by professional malpractice. The Canadian courts do not recognize the legal doctrine of *res ipsa loquitur*, which has been used in United States courts in certain cases to reverse the normal burden of proof on the part of the plaintiff by requiring the defendant to prove that he was not negligent in the incident at question.

OBTAINING MEDICAL TESTIMONY IS OFTEN DIFFICULT FOR CANADIAN MEDICAL MALPRACTICE PLAINTIFFS

A number of the Canadian medical and legal experts contacted pointed to the plaintiff's difficulty in obtaining expert medical testimony as a prime reason for the low number of medical malpractice suits in Canada.

Roger Carter, Dean of Law at the University of Saskatchewan, wrote, "In most instances, of course, this (prosecution of a medical malpractice suit) will necessitate the plaintiff being able to find and call expert medical testimony. Perhaps understandably, there is something of a wall of professional silence which many a litigant will run into in attempting to get this kind of assistance from a doctor."

A Canadian medical school Dean, Dr. W. A. Cochrane, of the University of Calgary, wrote, "Physicians generally in Canada have been less interested and less enthusiastic about testifying against each other than perhaps [are physicians in] the United States."

Still another expert, John F. McCreary, M.D., Coordinator of Health Sciences and Dean of Medicine at the University of British Columbia, characterized the Canadian medical profession as ". . .a relatively tightly-knit group." He went on to write, "Perhaps partially because we have a poorer physician population ratio than exists in the United States, and physicians are therefore busier, the lawyers find it difficult to find a physician who will go to court to testify against another physician."

Although the dearth of expert plaintiff medical witnesses appears to be a serious problem throughout Canada, in at least one city, Toronto, the local medico-legal society has a policy of providing medical experts to testify in those cases in considers "meritorious and bona fide." A society spokesman said the society recognized that the "conspiracy of silence" on the part of the medical profession often only aggravates the malpractice problem and gives the medical profession bad newspaper publicity.

CANADIAN COURTS TEND TO BE PSYCHOLOGICALLY ORIENTED IN FAVOR OF THE PHYSICIAN AND MAKE FEWER AND SMALLER MALPRACTICE AWARDS.

In Canada, the doctor's position and high regard place him in a different climate than that of the United States doctor. According to Canadian legal author E. Jacques Courtois, "The courts take great pains to avoid any hindrance to the practice of liberal professions. They carefully refrain from meddling in their fields of activity and intervene only when very obvious injustice occurs." Mr. Courtois goes on to say, "It is with considerable reticence and always with great care that a judge will make up his mind to charge the individual engaged in medical practice with error."[2]

Although the belief has not been documented, some experts, including Leon Getz, Law Professor at the University of British Columbia, feel that American courts tend to stretch the principles of tort liability in order to compensate a disabled patient while Canadian courts tend to concentrate more on the question of actual liability of the doctor for the injury, regardless of the patient's hardship.

JURY TRIAL IS NOT COMMON IN CANADIAN MALPRACTICE CASES.

A Canadian medical malpractice trial is more likely to be held before a judge alone than is a medical malpractice trial in the United States. Trial by jury is usually refused in Canada on grounds of complicated medical evidence. Canadian legal and medical experts tend to think this use of trial by judge rather than trial by jury results in smaller awards in those cases decided for the plaintiff. They believe that judges are more prone than juries to base their decisions on technical data and less apt to be swayed by emotional factors. Even when juries are used in Canada, the trial judge is allowed to exercise more control in terms of advice and approach to the task than an American judge is allowed to exercise.

Law Professor J. B. Dunlop, who teaches courses in civil liability for personal injuries, including medical malpractice, at the University of Toronto, pointed out that only half of all personal injury actions in Canada are tried by juries and that awards are much smaller than awards in the United States, particularly in medical malpractice cases. He also reported that Canadian appellate courts are more prone to reduce high malpractice awards than are American appellate courts.

RELATIVELY SHORT STATUTES OF LIMITATION'S EXIST IN CANADA.

The statutes of limitation applying to both minors and adults are generally somewhat shorter in Canada than in the United States. Seven of Canada's provinces, for example, have one-year statutes of limitation and two provinces have two-year statutes. Only one province has no statute of limitation's. Where the statutes of limitation's exist in Canada, they commence not from the date when the negligence was discovered but from the date treatment of the matter complained of terminated.

THE CONTINGENT LEGAL FEE IS RARELY USED IN CANADIAN MEDICAL MALPRACTICE CASES.

Although the contingent legal fee is not generally used in Canada and most lawyers charge their clients on an hourly basis, use of the contingent fee is permitted in six Canadian provinces, including New Brunswick, Quebec, Manitoba, Saskatchewan, Alberta, and British Columbia. The lawyer's share of the award under the Canadian contingent fee system, however, is usually only from 15% to 20%, considerably smaller than the average one-third taken by American attorneys.

Even where the contingent fee is permitted, then, one can well understand why Canadian attorneys might not be as anxious as American attorneys to accept medical malpractice cases on a contingent fee basis. Canadian attorneys would be working for a smaller share of a less probable, smaller award.

Without access to a contingent fee arrangement, plaintiffs must pay for their attorneys' services even if their cases are lost. The prospect of taking on this financial responsibility, win or lose, well may act as a deterrent for many prospective Canadian plaintiffs.

If the unavailability of the contingent legal fee were the main reason for fewer medical malpractice cases in Canada than in the United States, however, one would expect a correspondingly small number of other personal injury suits to be filed. It should be pointed out in this regard that several of the medical and legal experts queried for this study mentioned that the disparity between the volume of all personal injury litigation in the United States and in Canada is much less than the disparity between the volume of medical malpractice cases in the two countries. No figures to refute or substantiate this contention were supplied, however.

THE LOSING CANADIAN PLAINTIFF MUST PAY A PORTION OF THE DEFENDANT'S LEGAL COSTS.

Not only must the plaintiff pay his own lawyer, in most cases whether he wins or loses, but if he should lose he is also required by Canadian law to bear a substantial portion of the defendant's legal costs. This places an additional economic incentive for caution before the prospective plaintiff who has a speculative case.

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[2] E. Jacques Courtois, Q.C., "Legal Responsibility," *The Canadian Nurse,* December, 1964.

THE UNAVAILABILITY OF LEGAL AID TO THE POOR DISCOURAGES SUITS.

Although there has been an attempt made to provide free legal aid services to Canadians in the lower economic brackets, several of the Canadian law and medical experts queried thought that these programs were underdeveloped. They believed that if free legal assistance were available, a larger number of medical malpractice actions would be filed than are filed at present.

CANADIAN CONSUMERS ARE LESS CONCERNED WITH MEDICAL MALPRACTICE THAN CONSUMERS IN THE UNITED STATES.

On the whole, Canadians appear to be much less concerned with a "medical malpractice problem" than Americans are. The Canadian media reportedly tend to give relatively little publicity to Canadian malpractice cases. Those malpractice cases that are publicized are usually large American ones. To quote Professor Linden again, "Canadians do not seem as 'claims conscious' as Americans. This is in part due to their less aggressive nature, perhaps, but also to the widespread existence of social welfare schemes which make lawsuits unnecessary."

Some legal and medical experts indicated that the excellent doctor-patient rapport that exists particularly in the rural areas of Canada tends to mitigate against patient initiation of malpractice suits. In the urban areas, the legal and medical professions have formed strong associations to achieve an easy flow of information about their professions and reduce misunderstanding.

THE MALPRACTICE PROBLEM IN GREAT BRITAIN

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Peter Baylis

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I. The Medical Defense Union

In Great Britain medical practitioners do not cover themselves against malpractice actions by commercial insurance; this is the function of the medical defence organizations which are not commercial organizations but mutual benefit associations of doctors administered by doctors. The Medical Defence Union is the largest and oldest of the three British defence associations and has a membership of over 71,000.

It was during the early 1880s that members of the medical profession in Great Britain noted that attacks on doctors were increasing in number, and that many prosecutions, or threats of prosecution, were actuated by malice or based on frivolous pretexts. Two cases in particular roused the indignation of the profession.

Two doctors had performed a tracheotomy on a child suffering from diphtheria. They instructed the father to suck the tube to remove any obstruction. The child died and the father contracted diphtheria. The father instituted a charge of manslaughter. The doctors were acquitted and the father then brought an action for negligence. There were two trials as the first jury could not agree. In the second trial the jury, after hearing the plaintiff's statement, thought it necessary to hear defendants' counsel and the action was stopped. Even so the doctors incurred costs of over $2,600, to say nothing of the anxiety which they must have endured.

In the other case a doctor was sentenced to two years' imprisonment with hard labour. He had been attending a women during her pregnancy and was convicted of an attempt to commit a sexual assault. The profession clamoured for his release and a petition was submitted to the Home Secretary expressing the view that the evidence failed to support the charge and that due weight had not been given to the fact that from childhood the patient had

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This report was prepared for the Secretary's Commission on Medical Malpractice, Department of Health, Education and Welfare under Contract No. HEW-OS-72-184. Report No. SCMM-PA-GB.

suffered from epileptic fits and was liable to delusions. Eventually the Home Secretary, on being satisfied that there was sufficient doubt, directed the doctors' release with a free pardon. By then the doctor had served eight months of his two years' sentence. It was generally believed that a conviction would never have been secured if adequate evidence had been submitted on this doctor's behalf.

In October 1885, the Medical Defence Union was founded with the object of protecting doctors against such risks. For the first few years the Union's membership remained at about 500. It had to fight for survival, convulsed by internal crises, and opposed by a new body formed by seceding members, and it narrowly escaped liquidation. Only the faith, courage and devotion of a little band of medical men saved it from extinction and set it on the path of development to become the great institution it is today, with over 71,000 members in all countries of the world, with the sole exception of the U.S.A. At present the Union has 11,000 members who practise outside Great Britain.

II. Services Provided by the Medical Defense Union

Only a handful of medical practitioners engaged in clinical work in Great Britain are not members of one or other of the three British defence organizations. It can be said without fear of contradiction that in Great Britain the members of the medical and dental professions are fully satisfied with the cover that they are afforded by their medical defence organizations.

The principal function of the Medical Defence Union is to defend and indemnify members in proceedings that are brought against them and that arise out of their professional work. In addition, members are entitled to advice on matters that are connected with their professional work. Furthermore the Union does not hesitate to initiate proceedings on behalf of members when their professional character and interests have been impugned. In every Annual Report reference is made to cases in which the Union has initiated proceedings on behalf of members who have been defamed. The following defamation is a typical example.

A. THE DOCTOR AND THE STRAIT-JACKET

A Sunday newspaper published a sensational article about a prisoner who had died in hospital. It was alleged that when he screamed with pain, while he was dying, he was put into a strait-jacket, that he had complained of severe headache for several weeks but had received treatment only with 'aspirin water' and that he had had no drugs to ease his pain. The man had died from a tumour in the silent area of the brain. Needless to say, the story about strait-jackets was nonsense, because they are no longer to be found in prisons. Until a few days before his death the patient had complained only of vague pains in the head and elsewhere. These complaints had been investigated and at no time had he been fobbed off with 'aspirin water' (the prisoners' name for a suspension of paracetamol in water). As the tumour developed, so far from 'screaming with pain', he became slowly more vague and disorientated and the correct diagnosis was made in the prison hospital. He was referred to a neurosurgical centre where the tumour was found to be inoperable. All the members of the medical staff of the prison, including two local general practitioners who did part-time relief work, were members of the Union, which took up the cudgels on their behalf. The story was traced to letters written by fellow prisoners to a Member of Parliament, who referred them to the newspaper whose reporter delved enthusiastically into the murky depths of prison rumour. Long before the trial the newspaper must have known that the story could not be supported since they had seen the meticulous prison records. In the end the paper paid substantial damages and the Union's legal costs. A statement was made in open court and published in the newspaper concerned and other daily and Sunday newspapers, which cleared the members of the unpleasant allegations made against them.

B. CRIMINAL CHARGES

Members are also defended when they have to appear before the criminal courts on charges arising out of their professional activities. One of the most celebrated cases in which the Union has ever been involved concerned the trial of its member Dr. J. Bodkin Adams.[1] The accused was charged with the murder of two of his patients. He was acquitted. The costs that the Union incurred in defending Dr. Bodkin Adams amounted to $46,800.

C. HOSPITAL MEDICAL OFFICERS

Members holding hospital appointments in the National Health Service are frequently assisted at hospital inquiries. Hospital medical officers in the N.H.S. also frequently seek assistance about their contracts, removal expenses and many other matters. In every Annual Report some of these cases are mentioned under the main heading of "Problems of Hospital Medical Officers in the N.H.S.".

D. GENERAL PRACTITIONERS

General practitioners are assisted when it is alleged that they have been in breach of their Terms of Service. Numerous cases of this sort are mentioned every year in the Union's Annual Report under the main heading of "Problems of General Practitioners in the N.H.S.".

E. ETHICAL INQUIRIES

The commonest ethical inquiry that the Union receives from its members relates to one or other aspect of professional secrecy and again many such cases are referred to in the Annual Reports.

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[1] *British Medical Journal* 1957, 1, 712; 1957, 1, 771; 1957, 1, 828; 1957, 1, 889; 1957, 1, 954.

F. DISCIPLINARY COMMITTEE OF THE GENERAL MEDICAL COUNCIL

Another type of case in which members are assisted arises from their appearance before the Disciplinary Committee of the General Medical Council. Disciplinary powers were first conferred on the G.M.C. by the Medical Act 1858, which established the G.M.C. and the Medical Register. The disciplinary jurisdiction of the G.M.C. is now governed by the Medical Act 1956 as amended by the Medical Act 1969 and these Acts provide that if any fully or provisionally registered practitioner

(1) has been convicted in the United Kingdom or the Republic of Ireland or any of the Channel Islands or the Isle of Man of a criminal offence, or

(2) is judged by the Disciplinary Committee of the Council to have been guilty of serious professional misconduct the Committee may if it thinks fit direct that his name shall be erased from the Register, or that his registration shall be suspended for a period not exceeding 12 months. The power of erasure applies also to temporarily registered practitioners. Again, cases of this sort are often referred to in the Union's Annual Reports.

G. INQUESTS

Members regularly consult the Union when they are asked to give evidence at inquests concerning deceased patients for whom they have been clinically responsible. It is often possible, by suitable inquires and by consulting expert colleagues, for the Union to resolve points of doubt or dispute. Legal representation is provided when it is thought that a member's conduct may be called in question. Four such cases are reported.

Natural Causes or Accident?

One of six partners in general practice informed the Union that there was to be an inquest on a coal miner whom he and two of his partners, also members of the Union, had recently treated. The man had lifted an iron bar while working underground and had felt a pain in his right chest. The next morning he attended the surgery of his family doctor and was found to have diffuse tenderness of the right chest wall but no other abnormal physical signs. He was certified unfit for work by reason of strained intercostal muscles and 18 days after the incident, when able to use his arms vigorously, he returned to work. He worked underground for a further 14 days without difficulty but then again consulted his doctor, complaining of a cough and pain in the right chest. There were crepitations in both lung fields, and he was confined to his house and treated with antibiotics. When a partner visited him four days later there were signs of a deep vein thrombosis in one calf. This partner had not seen the patient for some months and noticed a considerable loss of weight. In discussion at the surgery, the partners agreed that bronchial carcinoma must be suspected and arranged for the patient to attend hospital for chest x-ray, writing on the request form: 'Fleeting episode venous thrombosis. Crepitations in upper zones. Weight loss. ? bronchial carcinoma'. On the day on which the patient was to attend for x-ray, he suddenly collapsed at home with central chest pain and the partner who attended thought that he had had a coronary thrombosis; he arranged his immediate admission to hospital, but the ambulance men found the patient pulseless when they arrived; they carried out cardiac massage on the floor of the living room but without success. The general practitioners gave statements to the coroner's officer but, since they lived in a county where the police constable concerned had to submit all statements to police headquarters in another town, the coroner's pathologist was in the difficult position of having to perform the autopsy with only a brief and inaccurate history that the patient had suffered a blow to his chest and died after some treatment from his family doctor. Several fractured ribs were found with collapse of the left lung and the cause of death was reported to the coroner as pneumothorax, caused by laceration of the left lung by a fractured rib, received in an injury some time before death. It was clear that at the inquest it might appear that the general practitioners had failed to diagnose and treat injuries of the chest wall which from being curable had become lethal. The Union obtained the view of a thoracic surgeon, who suggested that the patient might have died of pulmonary embolism from the deep vein thrombosis, and that extensive damage might have been done to the chest wall by cardiac massage. The Union conveyed this hypothesis to the pathologist, through the coroner; the pathologist did not consider it to be a likely sequence of events. The Union, on behalf of the family doctor, applied to the coroner for exhumation and for a second and independent post-mortem examination. The body was exhumed five weeks after burial. A consultant forensic pathologist undertook the second post-mortem examination on the Union's behalf, in consultation with the coroner's pathologist who welcomed the opportunity to examine the case further. Additional fractured ribs were found and a small primary carcinoma of the left upper main bronchus was revealed on dissection of the lungs. There was also ante-mortem thrombus in the deep veins of both legs with multiple pulmonary emboli. The coroner's pathologist reported the fresh information, giving the cause of death as pulmonary embolus from a deep vein thrombosis, due to carcinoma of the bronchus. At the inquest the coroner recorded a verdict of death from natural causes; the question of death from injury underground, or from inadequate treatment of those injuries, no longer arose. While the affair caused distress to members of the family they were relieved to learn that the death was inevitable and was not the fault of his employers or doctors.

Aspirin Again

Members who have been summoned to give evidence at inquests on patients who have died of aspirin poisoning often consult the Union. The well known latent period after ingestion of the poison when the patient appears to be well deters the inexperienced practitioner from taking any urgent action.

A girl of 17, who had made many previous suicidal gestures, had been an inpatient in the psychiatric unit of a teaching hospital for some weeks and it was agreed that she should gradually be allowed to develop self-reliance by going out in the town alone for an hour or two in the afternoon. She would have been discharged home in two to three weeks. One evening she informed the house officer that she had swallowed the contents of a bottle of aspirin tablets, which she had bought during the afternoon. He made a careful physical assessment and found no abnormality. Knowing the patient to have made several similar unfounded statements in the past, he instructed that she be watched, and that any change in her condition should be reported to him. More than 12 hours later the patient's condition suddenly deteriorated, and she lapsed into coma from which she could not be revived. At the inquest, where the doctor was represented by the Union's solicitors, he explained that if he had been informed that the aspirins had been swallowed only an hour or two earlier, he would have washed out the stomach. He believed that the girl's story was false as her condition was entirely normal several hours after she stated she had taken the poison. The delayed onset of symptoms of aspirin poisoning is a common trap for the unwary doctor.

Death and Cardiac Massage

When driving home a provisionally registered house officer saw a man lying by the roadside and stopped his car to see if he could give assistance. The man's respiration had almost ceased, his eyes were open and his pupils fixed, no pulse could be felt, he had no heart sounds and was cyanosed. As the member thought that the man had had a heart attack he sent a bystander for an ambulance and applied intermittent mouth-to-mouth resuscitation and external cardiac massage. He felt ribs break while he was doing this. When the ambulance arrived there was still no spontaneous breathing and the practitioner accompanied the patient in the ambulance, still trying to revive him. On arrival at the hospital he and the casualty officer continued their efforts until they were satisfied that there was no sign of life. The member was later told that there was to be an inquest, and that autopsy had revealed no cause of death other than 13 fractured ribs. Arrangements were made to have a senior pathologist available at the inquest. The coroner's pathologist said that he had found no thrombosis but that there were multiple fractured ribs. From the history he had been given he had concluded that the ribs must have been fractured in an accident and he had attributed death to this, but when he heard the member's evidence he accepted that the patient must have had an acute heart attack and he agreed that the member had acted correctly. It later appeared that the only reason an inquest was held was the the police report had been so worded as to suggest that the member had not given his name and had disappeared leaving the patient by the roadside. The coroner returned a verdict of death from natural causes and complimented the member on his action.

The Intravenous Plastic Catheter

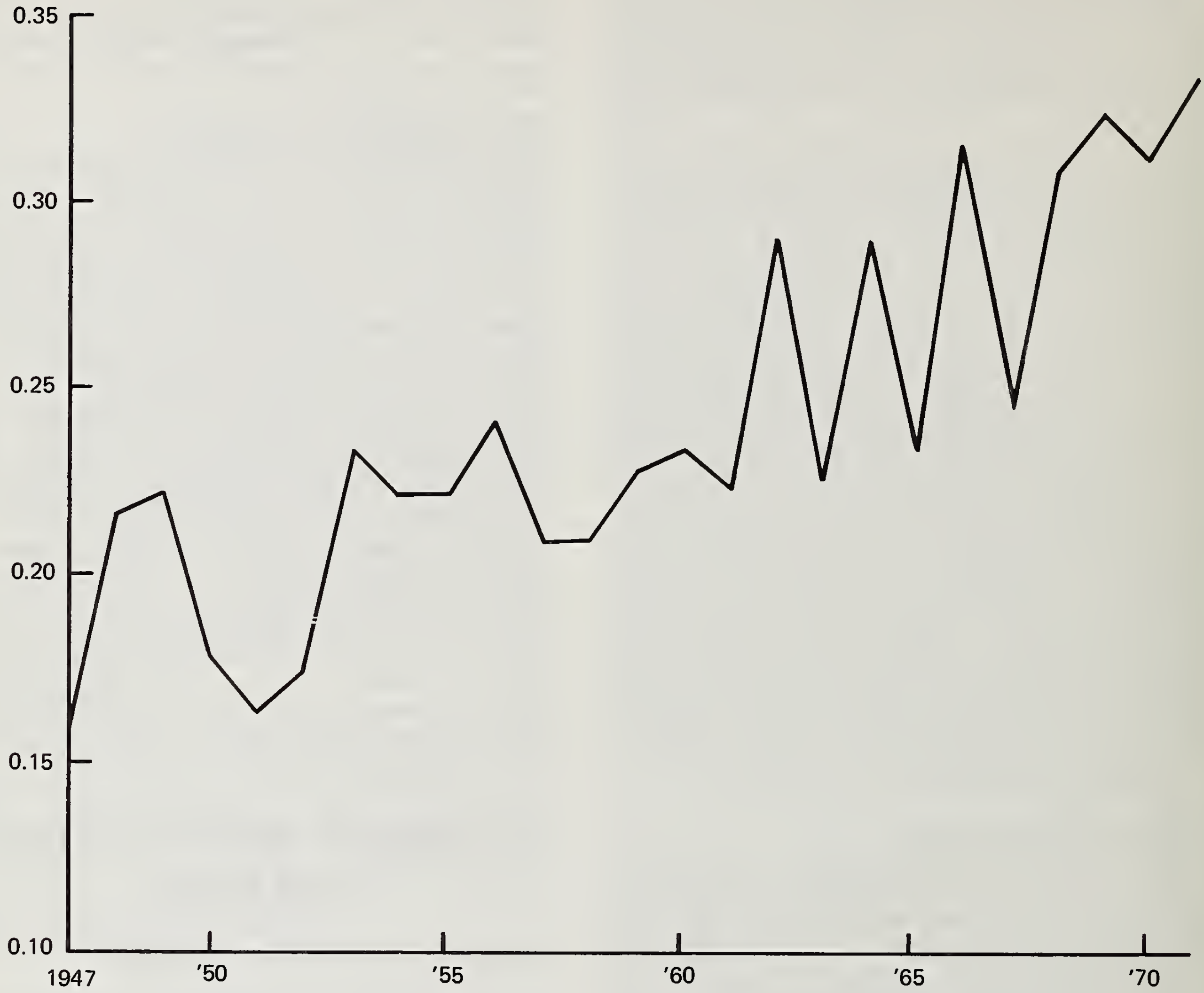
A house surgeon was instructed to set up an intravenous infusion on a confused and restless patient with severe pancreatitis. After sedation the catheter was inserted into a vein in the elbow and the arm splinted. Six hours later the catheter broke and the broken end slipped into the vein. By the time the house surgeon arrived the end of the catheter was already about half an inch deep in the vein. He made an incision under local anaesthesia but was unable to find the catheter. He applied a tourniquet and called the registrar, who made a second, equally unsuccessful, attempt and the consultant was called. The x-ray showed that the broken catheter was now lodged in the superior vena cava. When the consultant exposed the vessel it was found that the catheter had moved again. The heart was therefore opened, only to reveal that the piece of catheter had moved into the pulmonary artery. It was not thought to constitute a danger to the patient and no further extension of the operation was undertaken. The patient's condition deteriorated and he died 15 days later. Autopsy revealed no evidence of damage to the heart, and at the inquest the coroner said that he saw no reason to suggest that the catheter had been wrongly used; he recorded a verdict of accidental death.

III. Incidence of Malpractice Claims in Great Britain

A. MAGNITUDE OF THE PROBLEM

A following graph shows the percentage of MDU members involved in malpractice claims over the period 1947 to 1971. It can be seen that the percentage has doubled over the last 25 years.

Owing to the effects of inflation that has occurred on an unprecedented scale since 1965, the Medical Defence Union has had to increase its annual subscription very considerably. Whereas in 1969 members were required to pay an annual subscription of only $16, they will be required to pay an annual subscription of $65 as from 1.1. 1973. The amounts that are now awarded by the courts to successful plaintiffs have increased very considerably during the past few years. Needless to say, this increase is reflected in the claims that are considered to be indefensible and are therefore settled out of court. Whereas in 1965 the payments made by the Union on behalf of its members, in respect of damages and legal costs, amounted to $236,600 the corresponding amount in respect of 1971 totalled no less than $832,000. The increase in these payments during the last seven years is vividly shown in the following graph.



STATISTICS

Statistics for the 25-year period 1.1.1947 to 31.12.1971 :

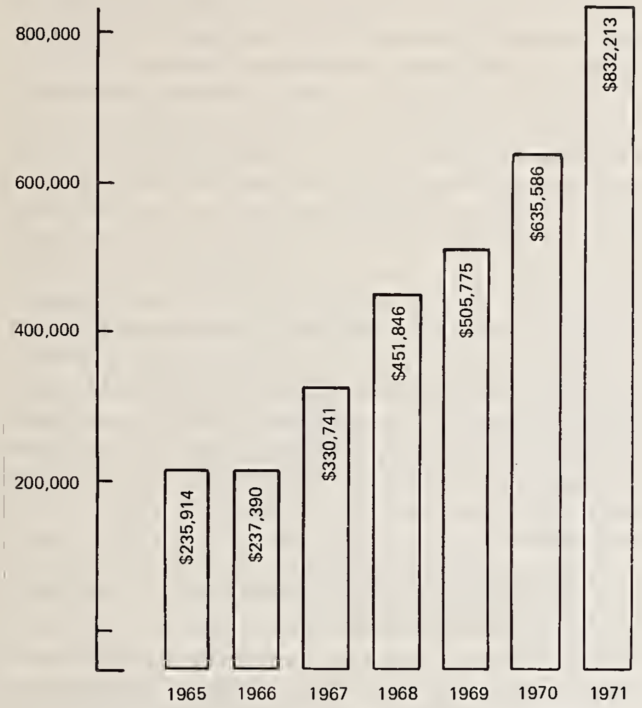
Number of malpractice claims and actions referred to and dealt with by the Union's solicitors	2,809
Number of actions contested in court	222
Number of actions contested and won	171
Number of actions contested and lost	51
Number of claims and actions settled wholly or in part by the Union	924
Number of claims and actions either abandoned by the plaintiffs or settled out of court by some other party without any contribution from the Union	1,448
Number of claims and actions referred to the Union's solicitors during period in question but not yet disposed of	215

In Great Britain medical practice is dominated by the National Health Service. This was created by the National Health Service Act, 1946, to establish

> "a comprehensive health service designed to secure the improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness."

Similar statutes cover Scotland and Northern Ireland. Treatment provided under the National Health Service is, in the main, free of charge. The cost is borne out of public funds and is recouped partly by National Insurance contributions and partly out of general taxation.

The National Health Service is divided into three main groups—Hospital and Specialist Services, General Medical Services and Local Authority Health Services. The Hospital and Specialist Services started with the transfer to the Government of almost all hospitals and medical and



ANNUAL TOTAL PAYMENTS OF DAMAGES AND LEGAL COSTS ON BEHALF OF MEMBERS BY THE MEDICAL DEFENCE UNION

ancillary staff working in them. There is a complex administrative structure controlling the hospitals and the services provided at them and all medical officers working in hospitals are employees of the relevant hospital authority. Consultants (Specialists) are sometimes employed whole time, but many work part-time and also engage in private practice. Most other hospital medical officers work whole-time. All are paid by salary and there is a system known as "Merit Awards" by which the service is made attractive to senior consultants by the payment of additional remuneration over and above their salary.

The hospital authority is vicariously responsible for the acts and omissions of all its staff in relation to the treatment of patients (Cassidy v. Ministry of Health).[2] Accordingly all hospital medical officers are required by the terms of their contracts to belong to a medical defence organization. In 1954 the three medical defence organizations covering Great Britain entered into an agreement with the Minister of Health (now the Secretary of State for Social Services) which governs the manner in which claims by patients involving both hospital authority and hospital medical officers are dealt with; the agreed arrangments in the Department of Health's circular H.M. (54)32 (Appendix I).

The General Medical Service is the service provided by the family doctor. It is administered by bodies known as Executive Councils for whom general practitioners provide services for patients and are paid largely on a capitation basis with a limit to the number of patients who may be included in their medical list. General practitioners are self-employed persons and they are not servants or agents of the Executive Council which has no vicarious responsibility for their acts or omissions in relation to the treatment of patients. Except to a limited extent general practitioners do not work in National Health Service hospitals. General practitioners are not required to belong to a medical defence organization, but almost all do so.

Local Health Authorities are responsible for such matters as public health, the care of the elderly outside hospital, child health, family planning and many others. The Local Health Authority is staffed by whole-time salaried medical officers assisted by a large number of part-time doctors, often married women. The Local Health Authority is generally vicariously responsible for the acts and omissions of its medical staff, but these are not required to belong to a medical defence organization. The fact that there are relatively few claims by patients involving doctors employed by Local Health Authorities has made it unnecessary for there to be any agreement with the medical defence organizations as in the case of the hospital medical officers.

B. FACTORS FAVORING CLAIMS

There is no real malpractice problem in Great Britain at present, but we are by no means sure that we shall not have one within the next decade.

This is suggested by the great increase in public interest in medical matters which is particularly evidenced by the news media. This is a country in which, like the United States, the news media are dominated by television and, unlike, we believe, the United States, by large circulation national newspapers. There are seven national newspapers which have a combined daily circulation of 14 1/4 million, the largest being the Daily Mirror, with a circulation of near 4 1/2 m. Newspaper and magazine articles and television and radio features deal constantly with the ills to which mankind is heir, and with the activities of doctors and hospitals—a doctor in trouble or a scandal in a hospital is automatically headline news. In a typical week the seven national newspapers we have mentioned carried a total of 139 items comprising 1,643 column inches on matters medical.

The doctor is no longer a man of mystery with his black bag. Cancer is no longer an unmentionable subject, and the correct diagnosis, however difficult, and the right prescription or surgery is looked for as of right, and there is, we believe, a slowly increasing tendency for the deprivation of that right to be regarded as an automatic entitlement to compensation.

Although an increase in litigation involving medical malpractice has been noted in this country, this has not been on the scale which is apparent in the United States. The increase that has occurred is due to two principal factors. The first is the impersonal element introduced by the National Health Service in 1948. The taking over of hospitals under the National Health Service Act has brought about a radical change in the attitude of the patient towards hospitals and their staffs. Although in the past many patients grumbled if they were not treated in hospital in the way they would have wished, they respected their local hospitals and the medical and nursing staff. Some of this respect has now gone and with it an inherent reluctance on the part of the patients to institute proceedings against their local hospitals. The attitude nowadays is that they are suing "the State". The general practitioner has also, in some measure, lost his status as the family friend and counsellor and his relationship with his patients has become, particularly in urban communities, more impersonal. This is especially so in large cities with floating, often non-indigenous, populations. The family doctor's relative immunity from malpractice claims has therefore diminished, although the hospital authority and the hospital medical officer are still the more common targets.

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[2] *Cassidy v. Ministry of Health* (1951). 1. All E.R. 574, 2. K.B. 343

The second principal factor arises from the introduction of our Legal Aid Scheme in 1950. This has made it possible for many members of the public, who would not have been able to afford to do so, to institute action against doctors and/or hospital authorities for alleged negligence. A person can hardly be blamed for instituting legal proceedings against a hospital authority in respect of injuries when he thinks, as so many do, that he is suing the State at the State's expense. Legal Aid (unlike medical treatment) is not available to all and is not always free. Eligibility depends upon income and the possession of capital. There is a complicated system of calculating eligibility but broadly a married man with two children ceases to be eligible if he earns more than $300 per month and Legal Aid is not available to those with $1,200 of available capital. Those who are within the Scheme but are near the top of the scale must pay a part of the legal costs themselves.

When Legal Aid is not available the hopeful litigant is not necessarily forced to rely on his own resources. The Trade Unions frequently give financial support to their members in personal injury litigation and this may extend to litigation involving allegations of medical malpractice.

C. FACTORS DISCOURAGING CLAIMS

Factors which we believe may have stemmed the tide of litigation in Great Britain are:

Our System In Relation to Legal Costs

In our courts costs are said "to follow the event". This means that the unsuccessful party is usually ordered to pay the legal costs of the successful party. The costs of defending a medical negligence action will generally range between $7,500 and $25,000 dependent upon the complexities of the case, and the fear of having to meet such a bill is a strong deterrent to the litigant with a speculative case.

The general rule we have mentioned is subject to two important qualifications. In the first place the costs which the unsuccessful litigant will be ordered to pay are what is known as "party and party costs". These are assessed by a court official on the basis of the minimum costs of defending the case and they usually amount to about two-thirds of the actual costs of the successful defence of the suit. The second qualification is that costs are seldom awarded against the unsuccessful litigant who is in receipt of Legal Aid. He can be ordered to make a contribution to the costs of the successful party if his financial position appears to justify it but this order is seldom made and when it is the contribution is generally not in excess of $250. It is possible for a successful litigant who would be out of pocket because his opponent has Legal Aid to obtain payment of his costs out of public funds. However, this only applies in the case of serious hardship and would not apply to practitioners assisted by the medical defence organizations.

The Prohibition Against Undertaking Legal Work On A Contingency Basis

We understand that lawyers practising in the United States are permitted to undertake litigation on behalf of a client on the basis that the lawyer will receive no, or only nominal, remuneration if the client's action is unsuccessful or a proportion of the damages recovered if it is successful. Such a practice is expressly forbidden to lawyers in Great Britain and it would be a serious disciplinary offence if it were proved that any lawyer in Great Britain had undertaken a case on this basis. Opinions differ in the legal profession as to whether this is a desirable and necessary inhibition.

The Absence of Juries In Civil Actions

Except in actions for libel and slander, civil actions in England and Scotland are now tried by a judge alone and not by a jury. Trial by jury has been retained in Northern Ireland and this has enabled us to observe the marked contrast in the difficulty of defending medical practitioners in cases tried by a jury. In a recent case in which the Medical Defence Union was involved a women alleged that she had been sterilized without her consent. It was demonstrated by the clearest evidence that the patient had consented to the operation and the judge summed up strongly in favour of the gynaecologist. However, the jury, doubtless influenced by religious convictions, disagreed and a retrial of the action had to be ordered. It was so unlikely that religious feeling could be kept out of the case, that the Medical Defence Union felt compelled to settle the case before the retrial took place. Such a case would probably never have been brought to court had the plaintiff not been able to rely upon the prejudices of a jury.

The Comparative Absence Of Private Medical Practice

Most medical and surgical treatment in Great Britain is provided under the National Health Service. Private practice exists and to an extent is helped by private insurance schemes but in general it is limited to the well-to-do. It is not, we think, cynicism to believe that the patient who has paid for his treatment is more ready to sue if he considers that the treatment was less than satisfactory. In truth we believe that, although they may grumble at the inevitable delays, the production-line type of medicine and the absence of the bedside manner, the people of this country on the whole are proud of the National Health Service and grateful that it has removed the fear that illness can be a crippling financial burden.

The Existence And Attitude Of The Medical Defence Organizations

Most British lawyers experienced in litigation are aware of the protection that is afforded to medical and dental practitioners by their defence organizations. They know that unless their client has a prima facie case the doctor's defence organization will resist the claim vigorously irrespective of the costs which will be incurred. It is not the practice of the defence organizations of this country to dispose of a claim on a nuisance basis. Insurance companies which indemnify motorists and others against personal injury claims and are concerned solely with profits to their shareholders will generally settle a doubtful claim if it is financially expedient to do so. The defence organizations, although under a duty to protect their members' funds, are non-profit-making organizations and are very much concerned to defend the reputation of their members from attack upon their professional skill and competence and are also concerned to discourage other unjustified claims.

It is appreciated that it is distressing to a member to be confronted with the possibility of a legal action. As the date of the trial draws near he begins to realise the risks that are inherent in all litigation. However unjustified the action may be the member may feel tempted to ask his defence organization to meet the patient's demand for compensation rather than face the ordeal of a public trial. Nevertheless the Union firmly believes that the settlement of an ill-founded claim is detrimental not only to the profession as a whole but also to the individual member.

The following four cases illustrate the Union's determination to resist a malpractice claim which it does not consider to be justified.

Spinal Anaesthesis

Mr. Justice McNair, in the Queen's Bench Division on November 12, 1953, gave judgment for the defendants in an action in which two former labourers alleged that they became paralysed from the waist downwards following the administration of spinal anaesthetics when they were operated upon at Chesterfield Royal Hospital on October 13, 1947.

The men, Mr. C. H. Roe, aged 51, and Mr. A. Woolley, aged 62, claimed damages from the Ministry of Health, as successors to the former trustees of the hospital, and Dr. J. Malcolm Graham, the visiting anaesthetist. Plaintiffs alleged the anaesthetic was negligently administered, and contended that their paralysis was caused by the phenol solution in which the ampoules were immersed before their operations.

The allegations were denied.

Ciba Laboratories, Ltd., manufacturers of nupercaine, the anaesthetic, who appeared as third defendants, were dismissed from the action earlier as having no liability. Professor R.R. Macintosh, consultant anaesthetist, giving evidence for the plaintiffs, said that the best method of sterilizing ampoules was by autoclaving. He had used nupercaine for spinal anaesthetics and did not think the anaesthetic caused the paralysis. He though the paralysis was caused by phenol.

Professor Brodie Hughes, professor of neurosurgery in the University of Birmingham, said that, if sufficiently concentrated, phenol would kill the nerve cells. He said it was a practice in 1947 to store ampoules in phenol. He knew before 1950 that it was possible for spirit to seep into ampoules through cracks not visible to the naked eye. In cross-examination he agreed that it was an accepted practice in Britain in 1947 to store ampoules in antiseptic solutions.

Dr. J. Carson, consulting neurologist, giving evidence for the plaintiffs, said he examined them in 1947; he thought the spinal injection caused the paralysis, and the most probable cause was a chemical irritant.

Sir Francis Walshe, consultant neurologist, giving evidence for the Ministry, said the plaintiffs' injuries were consistent with the use of spinal anaesthetics. He said their case histories were inconsistent with a corrosive poison such as phenol. If phenol had been responsible, he would have expected it to be dramatic at the onset and immediate in its effect.

Dr. Macdonald Critchley, consulting neurologist, said he thought the plaintiffs' condition was a most intense form of complication due to spinal anaesthetics. Their condition was typical of what was known to follow the administration, at times, of spinal anaesthetics.

Sir Hugh Griffiths, consulting surgeon, called for the Ministry, said he thought the plaintiffs' condition was caused by the anaesthetic injection.

Dr. Graham said he had given about 500 spinal anaesthetics before October 1947. Mr. Roe's operation was performed in the morning and Mr. Woolley's in the afternoon. The first indication he had of anything abnormal was when Mr. Roe complained of a headache during the operation. It was not until three days later that he knew something was seriously wrong. He said that in the case of Mr. Woolley the administration of the anaesthetics was perfectly normal. He had no idea what had happened to the plaintiffs until Dr. Carson had visited the hospital. In 1947 he did not appreciate the danger of phenol penetrating an ampoule through an invisible crack. Some weeks before the operation he had found a cracked ampoule in the phenol solution and rejected it. He spotted it at once. He denied that he casually examined the ampoules.

Dr. R.W. Cope, consulting anaesthetist, said that ampoules could be contaminated through invisible cracks. He did not think an ordinary competent anaesthetist would appreciate that in 1947.

Mr. Justice McNair, giving judgment, said the operations on Mr. Roe and Mr. Woolley were comparatively minor, but in each case the result was disastrous: both unfortunate men were now permanently paralysed from the waist downwards. The method of anaesthesia was in 1947 a well-known method, and no charge of negligence had been made in regard to the adoption of that method in these two cases.

The hospital's obligation was to provide a competent anaesthetist, which obligation it had undoubtedly fulfilled. In his lordship's view a specialist anaesthetist was in the same class as a visiting surgeon, and the hospital did not assume responsibility in law for his acts. Although Dr. Graham was responsible for the choice of anaesthetic and the activities of the theatre staff, he could not be regarded as being responsible for any of their casual acts of negligence. The hospital was responsible for any acts of negligence by the theatre staff on the basis of master and servant.

The judge said he found that the plaintiffs' injuries were in fact caused by contamination of the nupercaine by phenol. The percentage of such injuries following such anaesthesias seemed to be about 1 in 10,000. An explanation that in those rare cases the injuries were due to some personal idiosyncrasy of the patient was difficult to accept in these particular cases because the injuries to Mr. Roe and Mr. Woolley resulted from the same anaesthesia injected by the same anaesthetist on the same day. That seemed to point conclusively to some common factor in the two cases. Phenol was present in the theatre, because the glass ampoules containing the nupercaine were stored in a phenol solution of 1 in 40, after a temporary immersion in a solution of 1 in 20. Glass ampoules could crack, and if they did there might be a replacement of nupercaine by phenol, although the measure of replacement might not be capable of being noticed. In his lordship's opinion, therefore, phenol was the most likely common factor.

It was now clear that phenol could find its way into the ampoules through invisible cracks, but in 1947 the ordinary general run of anaesthetist would not appreciate that risk. The judge continued: "I accordingly find that by the standard of knowledge of competent anaesthetists in 1947 Dr. Graham was not negligent in failing to appreciate this risk." He also found that the theatre staff were not negligent.

His lordship added that, having seen Dr. Graham and heard him give his evidence in a forthright manner, he found it extremely difficult to believe he could have missed two visibly cracked ampoules. Plaintiffs' claim against the Ministry and Dr. Graham failed, and there would be judgment for both defendants.

Defendants did not ask for costs against the plaintiffs and no order was made as to costs.

The legal costs that the Union incurred in defending Dr. J. Malcolm Graham amounted to $20,020. Both the plaintiffs had been awarded a legal aid certificate and the Union was unable to recover any of its costs.

What Should The Patient Be Told?

In 1954 Lord Justice Denning, sitting as an additional judge of the Queen's Bench Division, in his summing up to the jury in the action of Hatcher v. Black and Others, restated the principles on which a doctor may be liable in an action for negligence by an aggrieved patient.

The facts were as follows. Mrs. Celia Hatcher, a young married woman of Belgian origin, aged 30, had done freelance broadcasting work from time to time which required the full use of her voice. She was sent by her doctor to St. Bartholomew's Hospital for examination. There she was seen by Dr. K. Black, who diagnosed a toxic goitre. He discussed with her the possible alternatives of a partial thyroidectomy or medical treatment, and advised her that operative treatment was the better course. The operation was done by Mr. E. Tuckwell, consulting surgeon to the hospital and dean of the medical school. When Mrs. Hatcher asked him on the night before whether there was any risk to her voice, he told her that there was none.

After the operation she found that her voice was not strong. After a fortnight as an in-patient she was sent for three weeks to a convalescent home, and when she returned it was found on examination that her left vocal cord was paralysed. She tried speech therapy with the hospital speech therapist, Miss Van Thal, who considered that the patient's prospect of recovering a useful voice had been quite good, but that she did not persist. Mrs. Hatcher found that although the quality of her voice was only a little less than before the operation, in use it became weak after a short time, and made her throat painful so that she was no longer able to broadcast.

Mrs. Hatcher's complaint against Dr. Black was that, according to her, he had negligently advised her that operation involved no risk to her voice, and that had she known there was any risk she would have chosen medical treatment, not operation. Her complaint against Mr. Tuckwell was that he had performed the operation negligently, and had damaged her laryngeal nerve. She also complained against both Mr. Tuckwell and the hospital governors that after the operation there had been a negligent failure to discover vocal cord paralysis.

In his summing-up Lord Justice Denning said that Mrs. Hatcher's counsel had compared her case to that of an accident on the road or in a factory. That was the wrong approach, because on the road and in the factory there would be no accidents if everyone used proper care. In hospital, where people who were ill came for treatment, there was always a risk no matter what care was used. It would be wrong, and bad law, to say that simply because a mishap occurred the hospital and the doctors were liable, and it would be disastrous for the community. It would mean that a doctor examining a patient or a surgeon operating at the table instead of getting on with his work would be for ever looking over his shoulder to see if someone was coming up with a dagger. An action for negligence against a doctor was like a dagger which could wound his reputation as severely as it could his body. The jury must not find a doctor negligent simply because one of the risks inherent in an operation had actually taken place, or because in a matter of opinion he had made an error of judgment. A doctor was only negligent when he had fallen short of the standard of reasonable medical care, when he deserved censure. An illustration was the first question raised in the action, what should the doctor tell the patient.

Mr. Tuckwell on the eve of the operation had told Mrs. Hatcher that there was no risk to her voice, although he knew there was some slight risk. This he had done for her own good because of the vital importance to her that in her condition she should not worry. He had told a lie which in the circumstances was justifiable. It was a matter which in law was left to the conscience of the doctor himself. The law did not condemn him if he did what a wise doctor so placed would do. None of the doctors called as witnesses had suggested that Mr. Tuckwell was wrong to tell her what ıe had, and if they did not condemn him why should the jury.

Mr. Tuckwell was also charged with carelessness in the operation, and it was said that it was his fault that the nerve was damaged. But all the doctors called as witnesses had said that damage to the recurrent laryngeal nerve was a well-known hazard of the operation even though all care was taken. No doctor called had suggested that Mr. Tuckwell in the course of the operation had done anything he ought not to have done.

As to the complaint about the post-operative period, it was not suggested that the operation injury had been aggravated. The jury might consider whether these complaints had not the colour of ingratitude, and whether Mrs. Hatcher's true nature was not better shown by her letter in which she wrote that she had had nothing but kindness at St. Bartholomew's Hospital.

The jury returned a verdict in favour of all the defendants, and judgment was duly entered for them with costs.

Failure To Diagnose

In 1955 a general practitioner, Dr. J.S. Rix, was visiting a general practitioner hospital, which has no resident staff, when a call was received from a local shop indicating that a butcher had cut himself in the abdomen. Dr. Rix, thinking that the patient might be in grave danger, immediately went to the shop where he found the patient sitting on a box smoking a cigarette and looking somewhat shaken. He was told that the accident had occurred whilst the patient was boning a rump of beef and holding the knife point downwards like a dagger and that the knife had slipped and cut his abdomen. He inspected the wound which was 1 1/4 inches in length and 2 1/2 inches to the left of and slightly below the umbilicus. Dr. Rix took the patient to hospital to make a more thorough examination and during the course of this examination he used a probe. He found that, although the deep fascia was cut, there was no obvious injury to the underlying muscle. He was unable to find any evidence to suggest that the peritoneum had been penetrated; he concluded, therefore, that the wound was superficial and told the patient so. He was conscious of the fact that there was an outside chance that the peritoneal cavity might have been penetrated. The wound was sutured and the patient was detained in hospital under observation for two hours.

Before the patient was sent home he was given emphatic instructions by Dr. Rix to call in his own doctor that evening and to tell him exactly what had happened and what had been done. The purpose of this was to guard against the "outside chance" of penetration. Dr. Rix did not see the patient again and he did not communicate with the patient's own general practitioner. The patient carried out these instructions and when he was seen by his own doctor, Dr. S. Mohr, that evening, he complained of nausea and abdominal pain on the side opposite to the wound. Dr. Mohr found no abnormality and he was told by the patient that the wound had been described at the hospital as "superficial." He concluded that the patient was suffering from a digestive disorder and he prescribed accordingly. He asked the patient's wife to call him the following morning if the abdominal pain persisted, but unfortunately she got the impression that there was no need to call him unless her husband's condition deteriorated. The doctor was not asked to visit the patient again until two days later, when he found signs indicative of an acute abdominal condition. Immediate arrangements were then made for the patient's admission to hospital. A laparotomy revealed a small perforation in the jejunum due to the knife wound. This was repaired but six days later the patient died following an inhalation of vomit.

The patient's widow sued Dr. Rix for negligence. Among the allegations that were made it was stated that Dr. Rix failed to take an adequate history, to have regard to an alleged "principle" that all wounds of the abdomen must be assumed to have penetrated the abdomen until the contrary is proved, to admit the patient to hospital and to write or telephone to the patient's own doctor giving his findings and conclusions and warning him of the "outside chance" of penetration.

The expert medical evidence at the trial was mainly concerned with two of these points. The first was whether the "principle" that all wounds of the abdomen must be assumed to have penetrated the abdominal wall until the contrary is proved was generally accepted. This implied the necessity for operation because it was agreed that there was no other way of proving non-penetration. The second point was whether the practitioner should have communicated with the patient's own doctor. On the first point there was a wide variation of opinion. One of the expert witnesses maintained that hospitalization and immediate operation was the only course. Another said that hospital was the only place where adequate observation could be kept even if immediate operation was not essential. Others said that there was enough variation of circumstance to leave a field for the exercise by a practitioner of his clinical judgment. The defendant's case was that there are wounds which are clearly penetrating which should be dealt with by admission to hospital and operation, and others which have not penetrated the full depth of the skin which should not be admitted, and that in between there lies a field in which a practitioner is entitled to exercise his clinical judgment. This last situation requires that the doctor should have carried out a full and proper examination and made adequate arrangements for the supervision of the patient at home lest any signs of peritonitis should develop. All the expert witnesses and Dr. Rix agreed that it is impossible to exclude the "outside chance" of penetration other than by an exploratory operation.

There was also a wide variation of opinion on the second point. At one extreme it was said that a letter or telephone call was essential and at the other extreme an experienced general practitioner who was called for the defence said that he, as a member of the staff of another general practitioner hospital, did not write letters in such circumstances and would not have expected to receive one if he had been in Dr. Mohr's place. Other experts said that as a matter of "hindsight" a letter would have been advisable or desirable, but they went on to say that there was nothing which could have been put in the letter that the patient did not tell his own doctor, for it was admitted on all sides that it is a matter of general knowledge that the outside chance of penetration cannot be excluded except by operation. Against this it was argued that the fact that the patient had told his own doctor that the wound had been found to be superficial was a clear demonstration that to pass messages by the mouth of a patient might well lead to another doctor being misled.

The trial judge Mr. Justice Barry said that the practitioner had shown a keen helpful interest in the case and any negligence which might be found against him was certainly, in the circumstances of this case, no reflection upon his professional reputation. He said that the highest that the plaintiff put her case was that the defendant made a mistake or a series of mistakes which the best of us did on many occasions and that her submission was that in the particular circumstances the defendant's mistake or series of mistakes amounted to a lapse from the reasonable standard of skill and care which the law demanded from a general medical practitioner in the position of the defendant. On the first of the principal topics mentioned earlier the judge held that although the better course for Dr. Rix would have been to arrange for the patient's admission to hospital, he was not negligent in failing to do so. The judge did not regard Dr. Rix's diagnosis as negligent. On the second point the judge said that, having regard to the "frightful risk" involved if a penetration of the abdomen was undiscovered and not treated, he was bound to hold that Dr. Rix was guilty of negligence in law in sending the patient home without ensuring that Dr. Mohr was made fully aware of the nature of the injury which the patient had suffered and aware of the dangers which might result from it in failing to give any adequate information to Dr. Mohr and indeed, in effect, in allowing him to be misled. It was on this point only that the judge found that Dr. Rix was negligent and he awarded the plaintiff damages of $23,530.

The case was then taken to the Court of Appeal. The defendant's appeal was against the single finding of negligence which had been made, namely that he had failed to communicate with Dr. Mohr. The plaintiff cross-appealed raising various other points, including the allegations that the patient should have been admitted to hospital and that an operation should have been performed. The cross-appeal was dismissed and the appeal of Dr. Rix was allowed by a majority decision. Lord Justice Morris, in a dissenting judgment, said that Dr. Mohr had in no way been criticised but it was clear that if he had received a communication from Dr. Rix he would have been made aware of facts which were not within his knowledge. He said that this question of whether the failure to send a communication was negligent was not one for which expert technical guidance was needed and as the facts were special this was not a case where some standard or normal routine medical practice could be said to exist. He considered that Dr. Rix was negligent in failing to communicate with Dr. Mohr. Lord Justice Romer concluded that, having heard two distinguished medical witnesses, one of whom was a surgeon and the other an experienced general practitioner, who had said that Dr. Rix's conduct had been reasonable in every respect in the circumstances, he was unable to find that Dr. Rix was negligent. Lord Justice Willmer, who also decided that the appeal of the defendant should be allowed, said that the material question was whether the practitioner, when he sent the patient home, ought to have appreciated that it was so vitally important to inform Dr. Mohr that the deep fascia had been cut and ought to have thought of the possibility that without this information the latter was likely to have been misled. That question had to be considered in the light of what Dr. Rix saw at the time and, although it was correct that it would have been better if the practitioner had sent a letter to Dr. Mohr setting out the importance of keeping the patient under close observation for the possibility of penetration, that was not a precaution which in practice was regularly adopted between general practitioners. Lord Justice Willmer decided that the finding of negligence against Dr. Rix could not be supported on the narrow ground on which it was based.

The plaintiff appealed to the House of Lords where the only point that was argued was the question of whether a communication should have been sent to Dr. Mohr. The House of Lords dismissed the plaintiff's appeal by a majority decision of three to two. The dissenting Lords of Appeal held the view that the practitioner should have foreseen that his failure to send a direct communication to Dr. Mohr would cause him to be misled. Those in favour of dismissing the appeal doubted whether the practitioner could have told Dr. Mohr anything more than the patient had in fact told him. They stated that, although it was easy after the event to say that if the practitioner had sent a message the patient might not have died, that was not the proper test.

Of the nine judges in all who heard the case, five considered that the practitioner was not negligent and four considered that he was negligent in failing to communicate. The plaintiff was given legal aid before the trial judge and before the Court of Appeal and there was no question of any of the costs being recoverable against her, although Dr. Rix was successful in the House of Lords. If she had succeeded before the House of Lords the liability of the Union would have been approximately $46,800, for the Union would then have been made responsible not only for Dr. Rix's but also for the plaintiff's costs.

Puerperal Septicaemia

In February 1963 a married women with two children made arrangements with her general practitioner, Dr. H. Cole, for maternity services. The baby was expected in early October. In August her fingers began to swell and on 4 October her wedding ring was filed off. Underneath the ring was a reddened area of about 1 cm diameter, within which there were three tiny septic spots. On 7 October the patient showed the doctor these spots during a routine antenatal examination. He looked at them, regarded them as trivial, and took no action. On 10 October the patient was taken into a local general-practitioner maternity home where her baby was born a few hours later. On 11 October the nursing staff noticed a reddened area on the ring finger and a similar area on one toe. The patient was isolated and the matron telephoned Dr. Cole to tell him about these reddened areas. He directed that a swab be taken of the septic spots and sent for culture and that she should be given a five-day course of tetracycline. Next day he found a small area of reddening on the toe with the appearance of having been rubbed by a shoe. There was no frank pus and little serous discharge. The finger was in much the same condition as it was on 7 October.

On 15 October the report on the finger swab stated that staphylococcus aureus and streptococcus pyogenes had been cultured; the staphylococcus was resistant to tetracycline and penicillin but sensitive to cloxacillin and erythromycin, while the streptococcus was sensitive to penicillin. Both the reddened areas had improved since he had seen them on 12 October, and the patient's general condition was satisfactory. The five-day course of tetracycline was completed, the last dose being given at 11 p.m. on 16 October. Next day Dr. Cole again examined the finger and the toe, and found that both were nearly healed. He decided not to prescribe further antibiotics. Both lesions had healed when the patient was discharged on 19 October. The following day she had symptoms attributed to 'clot colic'. The practitioner's partner, Dr. H.G. Peters, gave an injection of morphine following which she vomited.

On the morning of 21 October Dr. Cole was called to see the patient and found her apparently moribund. He arranged for her immediate admission to hospital where a diagnosis of fulminating streptococcal septicaemia was made. She recovered but she was left with neurological sequelae which produced speech and personality problems.

She brought an action against Dr. Cole alleging that her illness had been brought about by his negligent treatment. The evidence led the judge Mr. Justice Lawton to the following conclusions:

(1) a woman in the puerperium is particularly susceptible to infection: at this time, a streptococcal infection can be dangerous;
(2) if a woman in the puerperium becomes infected, the usual result is local sepsis of the uterus. If local sepsis of streptococcal origin occurs, signs and symptoms appear within 24 to 48 hours of the onset of the infection, which is easily diagnosed and can be easily treated by antibiotic drugs;
(3) it is now rare for local sepsis to lead to septicaemia, but if septicaemia does develop its clinical signs and symptoms can be easily treated by antibiotics;
(4) it is possible, although of the utmost rarity, for fulminating septicaemia to develop suddenly without local sepsis and without the normal clinical symptoms;
(5) the rarity of puerperal septicaemia is demonstrated by the fact that two experienced obstetricians called as expert witnesses for the defence had between them seen only one case. Puerperal septicaemia is also rare after the fifth day of the puerperium;
(6) the practitioner in the autumn of 1963 had good reason for believing that tetracycline, given orally, was effective against nearly all strains of streptococcus in his part of the country.

In the course of the action the patient's complaints were crystallized into the following:

(1) that the practitioner did not treat her finger on 7 October
(2) that he did not alter the antibiotic from tetracycline to penicillin and either cloxacillin or erythromycin when he read the pathological report on 15 October;
(3) that he did not continue treating her with antibiotics after 16 October.

She called as expert witnesses two pathologists and an obstetrician. Her third complaint was only supported by one of her expert witnesses. Dr. Cole, on the other hand, called as expert witnesses the two consultant obstetricians already referred to and two general practitioners with considerable obstetric experience. The judge described them as 'obviously very honest witnesses doing their best to help me in a very difficult case'. Each of them testified that in the position of the practitioner he or she would have acted as he did. The judge Mr. Justice Lawton held that the practitioner had not been negligent in respect of the first or second complaint referred to above, but that he had been negligent in respect of the third in not continuing to treat the patient with antibiotic drugs after 16 October, and he gave judgment for the patient for $6,500 damages and costs.

The case was taken to the Court of Appeal. The appeal was dismissed but the patient's cross-appeal in respect of damages was allowed, and the damages were increased to $10,400. The Court of Appeal refused to grant leave to appeal to the House of Lords. The House of Lords was petitioned for leave to appeal, the following reasons being cited:

(1) an important and far-reaching issue in the case as to when and in what circumstances an error of judgment

made by a professional man should be held to amount to negligence;

(2) an important and far-reaching issue was raised as to when and in what circumstances a practice which would be followed by a substantial number of competent and careful professional men might properly be held to be a negligent practice;

(3) if the judgment stood, medical practitioners would be unable, without the risk of being held to have been negligent, to omit any precaution to prevent injury to their patients, however remote the risk of injury. This, it was argued, would have a restrictive and undesirable effect on the conduct of general practice and on the exercise and development of professional judgment.

The Appeals Committee of the House of Lords was unimpressed by these submissions for it refused leave to appeal. From this decision no further appeal was possible.

An example of the different outlook on the two sides of the Atlantic is shown in the following extract from the Union's 1962 Annual Report.

"A passenger ship was sailing on the Tasman Sea enroute from Sydney to San Francisco when the ship surgeon was consulted by a woman complaining of severe abdominal pain. He diagnosed an ectopic pregnancy and advised immediate operation. The operation was successful and the patient's life was saved. However, when the surgeon was about to complete the operation he was informed that one of the swabs could not be accounted for. The swabs were re-counted, the surgeon explored the abdominal cavity but the missing swab could not be found. The surgeon decided that to prolong the operation would seriously endanger the patient's life and he closed the wound knowing that a swab "had probably been retained in the abdomen." The surgeon reported the loss of the swab to the patient's husband, who was himself a doctor, but not to the patient. She was advised to consult a doctor on disembarkation and was given a letter which described the operation but did not refer to the possible retention of the swab. It was not until two years later that the swab was discovered and removed. The patient then instituted proceedings in the Supreme Court of California against the ship surgeon and the shipping company, claiming that the condition which had resulted from the presence of the swab and the treatment associated with its removal entitled her to damages of $85,000.

Such a claim in England would be strenuously resisted but the Union was advised that an American jury would in all probability award the plaintiff damages and that the cost of the trial would be very high. After protracted negotiations the plaintiff's claim was settled for $7,500, of which the shipping company paid 40 per cent and the Union the remaining 60 per cent. Following normal American practice the patient had to pay her own costs."

D. DAMAGES

The level of damages awarded by the British courts for personal injuries is steadily rising. Examples of awards are as follows:

Death

Deceased male, aged 39. Insurance company claims superintendent earning $4,680 a year. If had continued in that post would have been earning $7,800 a year in ten years' time. Conscientious, hard working, careful man of considerable intelligence. Serious possibility rather than probability, of promotion to assistant claims manager. Loss of earnings assessed at $7,540 a year gross. Left widow, aged 35, and three children, aged fifteen, eight and four. He paid $345 a year towards education of eldest daughter. Dependency assessed at $4,589 a year, being three-quarters of deceased's estimated net earnings, and multiplier of 19 years' purchase applied. School fees for eldest daughter assessed at $1,950. Deduction of $1,235 made in respect of possibility of widow remarrying and $120 in respect of moneys received from deceased's estate. Agreed funeral expenses of $249. Agreed Law Reform Act award: $130. Fatal Accidents Act award: $69,550.

Quadriplegia

Male, aged 39. Married with four children aged between twelve and two. Had intended to become chartered accountant and had passed his intermediate examinations before doing national service in the Navy. Later decided to go into business and joined subsidiary of I.P.C. as managing accountant. After about two years became director and general manager earning $8,450 at time of accident. Considered by his employers as "very promising, dedicated to work, perceptive and achieving a grasp of operations above the normal." Would have been earning $10,400 a year by 1970. Very likely that would have become managing director and by age of 48 to 52 might well have been a divisional director earning up to $26,000. Had a chance of becoming a member of the main board of directors earning from $32,500 to $78,000 a year. Minor head injuries. Fracture dislocation of sixth and seventh cervical vertebrae. Quadraplegic. In hospital about seven months. Completely paralysed from below his shoulders downwards. Confined to wheelchair for rest of life. Arms down to wrists partially affected; could not move his fingers, cut up food or use a knife and fork. Could only write laboriously and not very well by lifting pen to his mouth. Could breathe only with his diaphragm, was incontinent and had to have his bowels evacuated manually. Could drink cold drinks normally but usually hot liquids had to be lifted for him and poured into his mouth. Wife had to turn him in bed two or three times a night and help him to dress and attend his needs in the morning. It took him about two hours to dress and leave the house in the mornings. Had to be lifted from his bed to his wheelchair. Escalator had been built at his home to take him downstairs. Had to spend whole day in chair, a car or in bed. Could never keep still for more than a minute to avoid sores. Employers had helped him to return to work by providing him with chauffeur to take him to and from work, charging him two-thirds of chauffeur's wages, his overtime and $5 a week for carrying plaintiff into and from car. Still earned $8,450 a year but could do only administrative work and had no prospects. Life expectancy was found to be 20 years. Additional expenses, including cost of mother's help for wife, assessed at $4,290 giving total of $51,480. Judge assessed average loss of future earnings at $7,050 a year and applied multiplier of 12 years' purchase giving total of $85,800. Pain and suffering and loss of amenity assessed at $45,500. Special damages $10,774. Total general damages: $182,896.

Multiple Injuries

Boy, aged 14. Injured when in car struck by train on level crossing in June, 1963. Severe brain damage and lacerations to left side of skull. Amputation of right leg below knee and toes of left foot. Extensive skin grafts to left leg proved unsuccessful and leg had to be amputated below knee 15 1/2 months after accident. Right-sided hemiplegia affecting arm and leg. Found it extremely difficult to walk on his artificial limbs without assistance. Suffered from impaired memory, lack of concentration and speech impediment. Had developed epileptic seizures. Would require depressant drugs permanently. In spite of drugs, there was still danger of recurrence of seizures at any time, especially because he was unusually vulnerable to falls. Would require constant supervision. Marriage prospects negligible. Recreation severely curtailed. Parents hoping to open catering business and hoped to be able to employ him in a clerical position. Judge awarded him $44,200 for pain and suffering and loss of amenities with interest at 7 per cent from date of service of writ; $10,400 for supervision and assistance; $2,600 towards cost of bungalow suitable for him to live; and $39,000 for loss of earning capacity. Total Damages: $90,200.

Pelvis

Male, aged 19. Run over by lorry when schoolboy aged ten or eleven. Fractures of pelvis and left hip. Damage to urethra causing stricture requiring dilation. Damage to nerves and blood vessels in pelvic area. Tear of bladder. In hospital about two months. Discharged on crutches. Fractures had healed well but could not run as well, had lost some agility and was liable to back-ache, though latter had been a risk owing to pre-existing pituitary gland condition. Some degree of urinal incontinence. Required periodical operations to dilate urethra which involved risk of kidney infection. Further operation might mean that dilations might diminish in frequency. Loss of sexual potency, but possibility that might recover it and had been a risk that would have become impotent apart from accident, so that not a case of total impotence. Had missed a great deal of schooling. Pre-accident reports were promising. Ability to enjoy life and earning capacity impaired. Now a counter hand earning $22 a week. Agreed special damages: $114. General damages: $23,400.

Wrist

Female, aged 39. Kitchen helper. Right-handed. Colles' fracture of left wrist. Some permanent limitation of flexion and aching in wet weather and on heavy pressure. Slight thickening of wrist. Ability to do housework and knitting impaired. Slightly increased possibility of future osteo-arthritis. Some restriction of range of work open to her. Agreed special damages: $73. General damages: $2,600.

E. CONSENT TO TREATMENT

For a number of years the Union has made a special point of emphasising to its members and to the profession at large the fact that no amount of professional skill can justify the substitution of the will of the practitioner over that of his patient. It has also repeatedly stressed the fact that a practitioner must not exceed the authority that has been conferred upon him by the patient and that if he goes outside the scope of that authority he may well be held to be liable in damages for assault. It is because of this propaganda that in Britain claims by patients for damages based on an allegation of assault are almost unknown.

In 1937 the Union, after consulting its legal advisers, prepared and recommended to the profession a form of consent for operative procedures. Although the wording of the original form has been amended in certain minor respects the form that we now recommend is virtually the same as that which we recommended in 1937.

In 1964 the Union issued a booklet on "Consent to Treatment" and many thousands of copies of this booklet have been distributed to members, hospital authorities and other bodies. The forms of consent that the Union recommends for use in various situations have been adopted by the vast majority of hospitals in Great Britain and these forms have received the approval of the Department of Health.

The Union has always stressed the fact that the obtaining of a signature to a consent form should not become an end in itself and that the most important aspect of any consent procedure is the duty to explain to the patient or relative the nature and purpose of the proposed operation and to obtain a fully informed consent.

Some years ago the Union was involved in an action which turned on the question of consent for hysterectomy.[3] The patient alleged that she had not consented to such an operation and that she wished to have children. The woman, who had entered hospital because of a recurrence of excessive menstrual bleeding, sued a gynaecologist for assault and negligence. At the trial of the action, which lasted eight days, she alleged that although when she signed the consent form she agreed to leave the nature and extent of the operation to the discretion of the gynaecologist, she thought it was to be no more than a curettage. The patient also alleged that the hysterectomy to which she had been subjected had been unnecessary and that she had wantonly been deprived of the hope of bearing a child. The gynaecologist's evidence was that there had been a full discussion with the patient, who had agreed that if at operation a hysterectomy was found to be necessary she would like this to be carried out at once. The gynaecologist said that, as the result of the curettage, she had concluded that the bleeding was due to chronic fibrosis and that as she knew from experience that curettage itself would not be satisfactory she had proceeded with the hysterectomy.

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[3] *Breen v Baker* (1956) The Times, 27 Jan 1956.

In his summing-up Mr. Justice Barry said that the first issue was whether the operation had been performed with the patient's consent. He said that he had no hesitation in accepting the evidence of the gynaecologist on this point. The second issue was whether the decision to perform the hysterectomy had been negligent and the judge said that he had to decide whether the gynaecologist had failed to exercise that degree of care and skill that a gynaecologist should devote to a diagnostic problem during the course of an operation. He concluded that the gynaecologist had not acted in any way improperly in performing a hysterectomy and he gave judgment for the gynaecologist. He said he was satisfied that the defendant had diagnosed fibrosis while doing the curettage and that it could not be said that there was negligence in removing the uterus of a woman aged 43 with fibrosis; the decision had been free from any taint of negligence and was a correct and proper one to take. Accordingly judgment was given for the gynaecologist.

Claims Handling

A. DELAY

A major problem in handling malpractice cases is the time interval between the alleged malpractice and the trial of the action in court. This is due in part to the pressure on the courts; for example, in London a case which is ready for trial will not normally be allotted the number of days necessary for the hearing for nine to twelve months. In part the delay is due to the essential complexity of malpractice actions and the need for both parties to obtain the advice and evidence of busy specialists. Moreover, although the lawyers who customarily represent the doctors are of necessity familiar with this type of action, it is generally fresh ground for the plaintiffs' lawyers and they are understandably slower at preparing their case. Delay too occurs if the plaintiff has to obtain legal aid for in a malpractice action this will not be granted until the plaintiff has at least one medical opinion which supports his claim.

We have known of cases in which ten years have elapsed between the cause of action arising and the final judgment of the court, and three years is a common interval. This delay results in memories fading, witnesses dying or leaving the jurisdiction, vital documents being lost or destroyed and this hampers the defence more, since on matters of fact the plaintiff frequently relies only on his own evidence and experience suggests that this remains vividly in the forefront of his mind.

B. DOCTORS FROM OVERSEAS

It is widely believed that the National Health Service, and in particular the hospital service, would be unable to function without the doctors, nurses and medical auxiliaries who come to this country from overseas. This creates problems in handling malpractice cases in which they are involved. Language is one problem, for sometimes these doctors not only have difficulty in making themselves understood to their patients, but if they become involved in a court action find it hard clearly to instruct their lawyers and to get their evidence across to the court. Furthermore, these doctors do not generally stay in this country for a prolonged period, and by the time the action which concerns them is listed for hearing, they may have returned to their native land and may be unwilling to return to give evidence even if they can be traced.

C. RECORDS

The most convincing evidence for an accurate diagnosis, an approved surgical practice or a correct line of treatment is a contemporaneous account of it in the patient's case notes. Such a record written at the time by the doctor in charge or his assistant without thought of possible litigation, is not only useful in the patient's subsequent treatment but is of inestimable benefit in combating a claim by the patient which may not be ventilated in court until years afterwards. For this reason, the Medical Defence Union is constantly at pains to advise its members of the importance of maintaining accurate case records which should be as full as time and circumstances permit, and the Department of Health and Social Security requires all patients' records to be preserved for a period of at least three years after the completion of the patient's treatment (H.M.[61] 73).

It would be idle to pretend that the propaganda on this subject which the Medical Defence Union publishes so assiduously has met with any marked success. Pressure of work, shortage of staff and poor command of English by many junior staff, no doubt contribute to the fact that in many cases in which malpractice claims arise the records of the patient's treatment are found to be woefully inadequate. This often presents a real handicap in the defence of the claim for not only is the contemporaneous record of the precise treatment inadequate to support the oral testimony of those responsible for that treatment, but the very fact that it was not recorded tends to throw doubt upon a doctor's evidence that such and such a clinical finding was noted or that a particular test was in fact carried out, although no one bothered to record the result.

In the Union's film "Ogden v. Bell" it is stressed that the quality of the doctor's medical records often assumes crucial significance in court proceedings. Many cases in the Union's Annual Reports demonstrate the importance of keeping detailed and accurate notes. Members are constantly reminded that the defence to a malpractice action may be severely prejudiced by the absence of written records. The film shows the great importance which the judge attaches to the notes made by the defendant doctor.

D. STATUTES OF LIMITATIONS

Under the Limitation Act, 1939, a claim for damages for personal injuries is statute barred unless the writ is issued within three years after the cause of action arose, unless the right of action was concealed by fraud on the part of the defendant or the claimant is under a disability such as mental illness.

An important breach in this defence was created by the Limitation Act, 1963. This provides that the three-year rule shall not apply if the material facts relating to his cause of action were, or included, facts of a decisive character which were outside the knowledge (actual or constructive) of the plaintiff until a date which—(a) either was after the end of the three-year period or was not earlier than twelve months before the end of that period and (b) in either case was a date not earlier than twelve months before the date on which the writ was issued. To take advantage of this provision, the plaintiff has to obtain the leave of a judge but it is a defect in the Act that the plaintiff's application to the judge is made ex parte and the proposed defendant is neither permitted to answer the application nor does he generally know even that it is being made. The Medical Defence Union sought unsuccessfully to establish that a defendant was entitled to apply to set aside an order obtained ex parte granting leave for the purposes of this statute on the grounds that the plaintiff had misled the judge to whom his application had been made.[4]

E. PROPOSALS REGARDING EXISTING PRACTICE

There are no current proposals for the modification of the handling of malpractice claims. It has been suggested that the whole question of compensation for personal injuries should be divorced from the concept of fault and blameworthiness on the part of a third party. This would leave it to the State to compensate anyone suffering injury by reason of the accidental action of another, the State recouping itself by taxation. There is limited precedent for such a proposal in the National Insurance (Industrial Injuries) Act which provides for modest payments, either lump sum or periodical payments for physical disability, partial or total, to employed persons who without fault are injuried whilst at work. Similarly there is a Government agency known as the Criminal Injuries Compensation Board which is empowered to pay compensation out of public funds to innocent persons injured by the criminal acts of others.

Whether such a concept has any merit in the general field of personal injury compensation is a matter of opinion. The Medical Defence Union would however be firmly opposed to the implementation of such a scheme in relation to medical malpractice claims. The Union is as much concerned with the protection of a doctor's professional reputation as it is with providing him with financial indemnity against any claim arising out of the exercise of his profession.

A recent change in court procedure has had a practical bearing on the handling of malpractice claims. Previously discovery of documents, that is to say the disclosure by each party of the documents relevant to the action, took place after the pleadings in the action were closed and represented the last step in the action before preparation for trial. It is now possible for a prospective litigant to apply to the court for an order for discovery of documents against the proposed defendant. The effect of this is that the patient's lawyers can obtain copies of the clinical records before the action by the patient is commenced. In fact this is often advantageous to those defending the doctors because it enables the patient's lawyers to obtain expert medical evidence on the patient's treatment as recorded in the notes and this sometimes had the effect of persuading the patient that he does not have a valid claim.

The Medical Defence Union considers that the best way of limiting malpractice claims is by educating the medical profession in the legal pitfalls of medical practice and by recommending to the profession the steps that should be taken to prevent or minimise the risk of a practitioner committing an avoidable error. Members of the medical secretariat are often invited to address local British Medical Association meetings and members of the legal profession are frequently invited to attend such meetings. In addition to addressing medical students members of the secretariat are often asked to address medical and surgical societies and other learned bodies. They also read papers at international conferences. Similarly the Dental Secretary is often invited to speak at local British Dental Association meetings and to dental students and other dental societies.

The Union attaches the greatest importance to its educational role in this field.

Because of the reecipt every year of members' reports concerning the factors which resulted in an avoidable injury to the patient, the Union is in a particularly favourable position to analyse the circumstances which lead up to these errors and to make recommendations regarding the steps that should be taken to eliminate or at least minimise the risk of committing a preventable mistake. It is because of this that during the past four decades the Union has played an increasingly important role in the education of its members and of the profession in general regarding the safeguards that should be taken to avoid the commoner preventable mistakes that are made by doctors and that result in harm to their patients.

Conclusion

We believe that in order to reduce the number of malpractice actions against members of the medical and dental professions it is essential that unmeritorious claims should be stoutly resisted, even though it would be more economical to settle. We are opposed to the settlement of a claim merely to dispose of an annoyance. We feel that the settlement of an ill-founded claim harms not only the individual practitioner but also the medical and dental professions. After such a settlement the patient may claim that he has been vindicated and others are thus encouraged to sue their doctors for real or imaginary injury. If the decision of the court of first instance is considered to be unsatisfactory and if the defendant's legal advisers consider that an appeal would be justified it is essential that appropriate action be taken to upset the decision irrespective of the cost of an appeal. A practitioner who successfully defends an ill-founded claim confers a benefit on his professional colleagues as well as on himself.

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[4] (Cozens v. North Devon Hospital Management Committee (1966) 2 All E.R. 799 Ca.).

We also believe that more attention should be paid to the teaching of legal medicine both to undergraduates and to postgraduates. It is only by constant propaganda—by articles, lectures, conferences and films on legal medicine—that members of the medical and dental professions will be made fully aware and reminded of their medico-legal responsibilities. Before embarking upon their professional careers practitioners must appreciate their legal obligations to patients and their relationship with lawyers. We do not believe that sufficient instruction is given to practitioners on medico-legal matters. We are of the opinion that much more consideration should be given to legal medicine in medical and dental education than is at present the case.

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